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The Malnourished Child

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Malnutrition is a much commoner condition than is generally supposed. Whether it is actually on the increase or whether our standards of judging children have changed, it is not easy to say. Possibly both conditions hold. The changed conditions in the modern home have certainly not helped matters a great deal. In addition, we have developed far beyond the stage where normal height and normal weight were considered sufficient evidence of good nutrition. We have come to appreciate more and more that nutrition is a qualitative and not a quantitative state. The "Height and Weight" day served its purpose exceedingly well. It succeeded in showing people that there was a need for improving the health of children of all economic classes. But if it succeeded in bringing to light a great deal of malnutrition that needed attention, it also succeeded in misleading a great many people into the belief that because a child was of normal height and weight he was well nourished.

What does the malnourished child look like? A typical picture of a fairly severe case would be somewhat as follows: The child is usually thin, but he may be fat and flabby. His muscles lack firmness. His skin is sallow or wax-like. There may be circles under his eyes. His posture is poor. Because of lack of proper muscular development, all his bony prominence may stick out. The chest is flat and narrow, the abdomen protruding. The general expression is one of apathy. There are two types of malnourished children, the slow, listless type of child, slow both mentally and physically, and the hyper-irritable type, always on the go, irritable, restless, and not on very friendly terms with either food or sleep.

With this picture before you, let us consider briefly some of the effects of malnutrition, and first of all its effect on mental health.

A prominent educationist has said, "Millions of pounds sterling are wasted yearly in England trying to educate the child who is not physically fit for education". This is not an idle statement delivered for effect; it is a statement the truth of which has been proven again and again. The war taught us a very valuable lesson on the effect of under-nutrition on children in the war zones. The under-nutrition of these children was the result of prolonged living on a diet low in quality and lacking in essential constituents. An investigation was undertaken, prompted by the complaints made by the teachers of mental deterioration of the children. There was a marked decrease in energy for mental tasks, inability to concentrate, slowness of comprehension, poor memory and inattention. One teacher reported that where she had been able to keep the attention of her class thirty minutes before the war, she now could barely keep it for five. There was a lowering of the whole standard of school work. The number of children failing to pass their grades was doubled; the number doing superior work dropped to one-half and the number doing inferior work rose by 30%.

And what of its effects on disease? Disease is sometimes at the back of malnutrition. This malnutrition is frequently associated with heart disease, nephritis and severe infections. If it is, then usually, with proper medical care, the cure of the disease means the disappearance of malnutrition. More often, however, malnutrition has its origin in bad living, bad and insufficient food and bad hygiene. What we dread is not disease as a cause of malnutrition, but disease that follows malnutrition. Let us take tuberculosis as an outstanding example. Tuberculosis is not always the dread disease it is commonly pictured as being. Tuberculosis may be present in an individual, and yet that person will show no apparent evidence of it. As a matter of fact, most of us by the time we reach the age of fifteen or thereabouts, have the germ of tuberculosis in our system, and yet relatively few of us develop manifest disease. One of the most important factors in holding tuberculosis at bay is bodily resistance—and bodily resistance and bodily nutrition are very closely related. Let me quote you a rather similar example in nature. There is a fungus which can and does infect the corn-fields. If the soil is good, the corn grows and matures normally even in the presence of the fungus. If the soil is inferior, however, the fungus grows wildly and destroys the corn-fields. So also with tuberculosis; bodily resistance may become so lowered by malnutrition that a small amount of infection marches on to become serious disease.

It is the latter problem that concerns us today. The tuberculous death rate in England has been observed to rise and fall with the price of bread. Dr. Stewart of Ninette, in a recent address pointed out that tuberculous deaths increased in poorly-fed war-time Britain, but not in the better-fed army, even in all the horrors of the trenches. In well-fed America the tuberculosis death rate continued to decline throughout the war. In Germany the tuberculosis death rate rose very markedly during the war, but has since returned to a pre-war average. "This disease that waxed to a scourge in war-time waned as rapidly once the better conditions of peace-time were restored." It is extremely sensitive to changes in the standards of living.

All of which means that if we have a child with tuberculous infection the disease may never manifest itself so long as the child is kept in good physical condition. But if nutrition suffers, if the food is bad or there is not enough food, infection becomes disease and the child becomes a hospital patient and a financial burden on the community.

I should like to refer very briefly to those diseases of malnutrition which are directly related to diet. Medical science has made rapid advances in this field in the past twenty years. Rickets, scurvy and pellagra have ceased being the problems they were ten and fifteen years ago. They can all be prevented by simple dietary measures and if, through ignorance or oversight they do occur, they can be cured by the same measures. It is difficult to believe now that Vasco di Gama only achieved his pioneer voyage around the Cape of Good Hope at the cost of 100 deaths from scurvy out of a crew of 160. With the newer knowledge of nutrition, all this could have been prevented, and by the exhibition of fresh fruits and vegetables not one of those men would have died.

During the war Denmark was exporting all its butter and butterfat, so that Danish children subsisted practically entirely on pasteurized skimmed milk. As a result, there was an epidemic of blindness among the children of Copenhagen. These infants were at first treated in the Eye Department of the hospital without success, since the cause of their blindness was not at once apparent. They were all poorly developed, weak and anaemic, and some of the younger ones were practically wasted. Then it was discovered that they had been fed on practically nothing but skimmed pasteurized milk, and the prompt administration of fresh whole milk and cod liver oil to supply the missing vitamins resulted in the restoration of sight to a great many of these children.

And now let us consider for a few minutes some of the causes of malnutrition. The three great causes are *POVERTY, IGNORANCE and DISEASE,* and the greatest of these is ignorance.

Disease, I think, we have considered in sufficient detail. If definite disease is the cause of malnutrition, then the cure of disease means the disappearance of malnutrition.

Ignorance and ooverty, however, are probably more often a cause of malnutrition than even specific disease. Ignorance is not confined to the poor by any means, but poverty takes away the defences by which the effects of ignorance may be evaded.

It is relatively easy for the average person to understand that a child may be malnourished because of poverty which makes it impossible for his parents to purchase food and other necessaries of life. But it is a little difficult to believe that in homes of fair economic comfort and even wealth, malnutrition should exist. Yet it does. Malnutrition is more frequently the result of poor quality than insufficient quantity of food.

Our target, therefore, narrows itself down to poverty and ignorance. We can, unfortunately, for the present at least, neither cure nor prevent poverty. But we can and must combat ignorance.

It must be obvious that the most effective as well as the most economical method of approach is through the child. The child of today is the parent of tomorrow. By working with the child and teaching him the principles of good food and good hygiene, we are not only preventing malnutrition in that child, but we are also to a great degree preventing malnutrition in the next generation. With the expenditure of the same amount of energy the results are much more lasting if we deal directly with the children than if we deal indirectly through the parents.

Progress in Winnipeg so far has consisted of follow-up work in conjunction with out-patient clinics and of a few nutrition classes held in various parts of the city. More recently nutrition classes have been started in a few of the city schools. For the most part, however, the work has been done in conjunction with the hospital. Cases of malnutrition, either alone or in combination with other diseases, have been picked out and sent to the Nutrition Department for supervision. The nutrition worker has followed these cases to their homes and by repeated visits and tactful discussion has sought to gain the assistance and co-operation of the mother in helping to remedy the conditions which have brought about the unfortunate state of affairs. Very often it is a matter of dire poverty which prevents the only too willing mother from giving her children proper and sufficient food. More often, however, it is a case of out-and-out ignorance, and the child suffers, not from lack of sufficient food, but rather from a lack of proper food. In these cases a little explanation flavoured with a good deal of tact, so that the mother does not feel that she is being dictated to, usually results in the desired change in diet being brought about, often without any increase in the demands on the family pocket-book.

The nutrition classes have produced very gratifying results. The children have a real desire to become physically fit, and they often go home and request the things they formerly refused. "If the parents at the same time are taught the essentials so that they provide what the child needs, and so take advantage of the child's interest and changed point of view, the results in improved nutrition, general health and habits of living are often little short of spectacular" (Roberts).

And what of the future? Our work so far has consisted largely in "salvaging". We have picked out the malnourished children and tried to cure them. If our work is to be of lasting benefit we must prevent rather than cure. We must seek the well child and keep it well. Nutrition work will undoubtedly gradually shift from the hospital to the school and the tendency in the future will be to prevent rather than to cure. A child who has been malnourished and has been treated for it, is never as well as a child who has never been allowed to become malnourished. With the pooling of resources and increasing co-operation between parents, children, nutrition workers and educators, we may look forward to an age when malnutrition will be a rarity and good health and bodily vigour the law of the land.

Mental Hygiene

By **MRS. W. T. B. MITCHELL, B.A., R.N., Director of Parent Education, The Mental Hygiene Institute; Chairman, Section of Education, Canadian Council on Child and Family Welfare.**

The story of the background upon which Mental Hygiene developed is at once informative, interesting and essential, in order that we may see in its proper perspective the progress of the past three decades in the care and treatment of the insane, the prevention of mental disorder and the preserving of Mental Health.

In the early ages, medicine was not a science, but was largely concerned with incantations, ceremonials, exorcisms, to be used in freeing the sick person from the demons that were supposed to possess him. Folk lore, the records of ancient civilisations and the customs of primitive peoples today, give many instances of belief in the supernatural causes of mental diseases, and methods of magic and priestcraft to free the "insane" person from the "spells and influences" that were supposed to be operating to cause his illness.

Because people usually fear what they do not understand, we can readily see how it came about that people suffering from mental disease, which was attributed to magical or supernatural influences, were burned, tortured, hanged or drowned in order to protect the well people.

It was not until about the twelfth century that any provision for hospital care of the insane was made. Even then, while in certain places the treatment of patients was fairly humane, in most places it was horribly cruel. Garrison, in his "History of Medicine," says of the famous "Bedlam" hospital and others, "the public was allowed to view the insane, like animals in a menagerie, upon payment of a small fee".

During the sixteenth and seventeenth centuries, many hospitals for the insane were established, but there was little improvement in the attitude toward the mentally ill or their care. If violent or disturbed or troublesome, the patients were subjected to cruel restraints of many sorts, caged, chained, strapped to beds or walls, frequently starved and usually beaten.

The eighteenth century brought the first beginnings of speculations as to the possible relation beween the emotions—fears, great sorrows, angers—as causative factors in mental disorder. Phillippe Pinel, in France, after strenuous efforts and with great personal risks, succeeded in doing away with the flagrant abuses and restraints to which the mentally ill were subjected, and providing for them humane and intelligent treatment and psychological study.

The situation in America was practically the same. We are all familiar with the "witchcraft" prosecutions of Colonial days. The first institutional care of the insane was provided in Philadelphia in 1732. At this almshouse, the insane were confined in cells, and here too a small fee was charged for allowing the curious to gaze at or talk to them. As late as 1882, Mr. Stephen Smith, Commissioner of Lunacy in New York, says in a report, "every form of appliance for the restraint of the disturbed was to be seen in common use," stocks, chains and dungeons.

By 1850 the place of the state or provincial hospital as the best provision for the custodial care of the mentally ill, was recognised, and throughout the United States and Canada the number of such institutions was gradually increased during the nineteenth century. There has been constantly, and still is, the problem of inadequate housing provision, and the belief in the necessity for physical restraint for the mentally ill is very slowly giving place to more intelligent and scientifically humane methods of control.

Upon this brief historical background, the story of the beginning and rapid development of the Mental Hygiene movement is a fascinating one. In 1908, Mr. Clifford Beers, a graduate of Yale, who had been a patient in both private and public hospitals for the insane, published a book which told in dramatic and convincing manner his experiences in these institutions. The book, "A Mind that Found Itself," gives a very vivid picture of the cruelties and abuses and illogical treatment to which the mentally ill were subjected at the beginning of the twentieth century.

After his recovery, Mr. Beers determined to devote his life to attempting to improve the care and treatment of the insane, and to arouse public and professional interest in the prevention of mental diseases. Prominent people who could give the necessary professional and financial support became identified with this plan and, in 1909, the National Committee for Mental Hygiene was formally organised. Since then its development has been phenomenal, ramifications diverse and influence far-reaching. In June, 1930, the First International Congress on Mental Hygiene was held in Washington, and representatives from Mental Hygiene organisations in thirty-six countries were present.

The Canadian National Committee for Mental Hygiene was organised in 1918. Dr. C. M. Hincks has been associated with the Committee from the beginning, and has acted as Director since 1924, and his unusual organising abilities and creative vision have largely contributed to the rapid growth and soundness of the Mental Hygiene programme in Canada.

The Canadian National Committee programme has three main objectives:

(1) Improvement of the care and treatment of the insane and mentally defective.

(2) Prevention of mental disorder and maladjustment.

(3) Conservation of Mental Health.

In carrying out the first objective (improvement, etc.), nine surveys of provinces and cities have been undertaken in order to arrive at a reasonable estimate of the actual conditions as to numbers of the mentally ill, defective or maladjusted, and the kind of provision being made for them. Following these surveys, recommendations for the improvement and enlargement of mental hospitals have been made and carried out, advancement has been made in raising the standards of care and treatment, and stimulation has been given to providing more adequate training for nurses and attendants as well as the medical profession, in the understanding of mental disorder and hygiene. The Committee has also co-operated with governments and boards of education in providing for special training and supervision for the mentally deficient individuals, and is still hopefully working toward more adequate provision along these lines. The surveys made, with the numerous educational contacts that were necessarily part of them, have succeeded in gradually awakening the public feeling in regard to the imperative need for more exact knowledge about mental disease, the care and education of the mentally deficient and the prevention of delinquency and crime.

The Canadian National Committee for Mental Hygiene has sponsored and supported the development of mental hygiene clinics and institutes in various Canadian cities, among the first being those at Toronto and Montreal. These clinics handle many adult problems of maladjustment, but put their main emphasis on helping with the treatment of behaviour problems and difficulties of adjustment of children, adolescence, college young men and women and family inter-relationships. The number of such guidance and treatment centers is being gradually increased throughout Canada, and we can look forward to the time when every Canadian city will be so equipped.

In following out the second objective, *i.e.*, prevention of mental disorder and maladjustment, the National Committee has also stimulated and supported research programmes, directed toward a better understanding of the genesis of mental disorder and maladjustment, toward therapeutic methods and techniques for their treat-

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ment, toward principles and measures of prevention.

In carrying out the third objective—conservation of mental health—the Committee has organised programmes of Parental Education through study groups. These groups are designed to educate parents in fundamental principles of Mental Hygiene and help them to integrate these principles and information in a practical way in the day-by-day training of their children thus conserving the mental health of the developing individual.

While a great deal of the effort of Mental Hygiene has been directed to the care and treatment of the mentally ill and maladjusted as already outlined, because of the urgency of the need, from the beginning there has been a consistent programme of research directed toward the better understanding and prevention of mental ill-health and maladjustment.

The approach of scientific workers to the study of the causes of mental disease and abnormal behaviour has been from two angles. For a long time it was thought that all mental disease must have *an organic basis*, that is, was caused by a specific physical abnormality of body, brain or physiological processes. Research along these lines continues, and it is definitely known that certain types of mental disorder *are* actually due to infection or injuries to the nervous system or to endocrine disfunction. But there are many types of mental disorder or maladjustment which it has not been possible to explain on a physical basis. Careful and exhaustive studies of such disorders have resulted in what we call the *psychogenetic* explanation or cause of abormal behaviour. That is, we have gradually come to recognise and accept the fact that many cases of mental disease or maladjustment do not suddenly appear full-fledged, but that they have their beginnings in early childhood, in simple and comparatively unimportant failures to adapt satisfactorily to life experiences, to environmental influences and training; that these simple emotional difficulties become more complex and elaborated and interactive as time goes on and after a more or less extended period of incubation, we see the culmination in behaviour problems of various sorts, in warped and twisted personalities, delinquency and crime and frank mental disease. People are not born stubborn, suspicious, hateful, queer, difficult, vicious; such character traits are developed as a result of the experiences and methods of training in their early and impressionable years.

Accepting this fact and its implications, we are brought face to face with a tremendous responsibility. We can readily see that in the development of his mental and emotional life, and the conservation of his mental health, the child needs as much, if not more, care, intelligent sympathy and understanding and guidance as in the nurturing of his body. If we want to conserve his mental health and insure for him wholesome personality development, then we must provide for the developing individual, through intelligent informed control of the training and environment, the *kind* of experiences that will enable him to build healthy rather than unhealthy emotional habits.

As we all know, the training and environment of young growing children are provided by their parents, teachers, nurses and others who have intimate contact with them during their plastic years. In the pre-school period there is no escape for the child from the influences of the parents' relationships to each other, their attitude toward their children, the atmosphere they provide, the training they give, the standards they set up. The *kind* of training, discipline or education that the child experiences in the pre-school period, determines largely the *kind* of adjustment or mental health and the type of personality developed. *In the hands of the parents lies the foundation of the mental health of the child and future adult.*

During the school period the teacher is daily faced with problems of unusual behaviour. The child who is trying to adjust himself to the daily-increasing demands made upon him by the curriculum, the school discipline, physical changes within himself, and teachers' attitudes, is apt to show the effects of the resulting conflict between his own wishes and desires and the necessity for conforming to social customs and standards in undesirable forms of behaviour or the beginnings of destructive personality traits. If the teacher handles these difficulties, which are merely symptoms of an underlying conflict, intelligently and unemotionally and constructively, she helps the child achieve socially acceptable, yet at the same time, individually satisfactory adjustments. *She conserves his mental health.*

We have stressed particularly the Mental Hygiene importance of the early years. White has said "childhood is the golden period for Mental Hygiene". This is the period of greatest plasticity and impressionability, and the time when habitual patterns of response, desirable or undesirable, healthy or unhealthy, are most readily built into the developing personality. This is the time when intelligent practice of the fundamental principles of *Mental Hygiene* will ensure for the child *Mental Health.*

And so we must face the tremendous importance of providing through lectures, written material, through individual contact and study groups, ways of educating and informing parents about the Mental Health hazards of childhood and how to avoid them, of helping them re-educate themselves and conserve their own Mental Health. We must provide such training for teachers as will give them insight into behaviour difficulties and personality maladjustments of childhood and techniques for the healthy handling of them. We must provide for all professions in which human contacts loom large, nursing, social work, industrial work, the essential knowledge of Mental Hygiene that will equip them to give special help in problems of personality and social contact.

Mental Hygiene is concerned with the whole life adjustment of the individual, since every period, infancy, childhood, school period, adolescence, adulthood and senility all have their peculiar problems of adaptation. It places great emphasis upon the importance of understanding the *whole reacting individual in relation to the total environment.* It is a comprehensive attempt to create more favourable conditions of living for men and women in all walks of life, and happier and healthier adjustments to the complicated social organisation of this age.

It is not a new discipline, but has drawn its techniques, methods, materials and information from a number of sciences—psychiatry, psychology, physiology, medicine, sociology. It has taken from each whatever has seemed to be of value, and has synthetised these contributions into a practical method of re-educating human nature and preserving Mental Health.

For instance, as a simple illustration, take the matter of food habits. The old method of following out the prescribed diets for children was to coax, force, frighten or bribe the child to eat the things we felt were necessary for his physical well-being. Parents were terribly concerned when children refused to eat and concentrated time and attention on the problem, much to the child's satisfaction and usually with little constructive result.

Mental Hygiene determines first from *nutritionists* what kinds and quantities of foods are necessary to keep children of varying ages healthy—from *domestic science* the best ways of preparing these foods so that they will be palatable and tempting to the eye, yet retain their vitamin activity—then makes a study of the findings of the *educationists* re rules of learning, value of repetition, effects of fatigue on learning, takes from *Psychology* information regarding the value and necessity of pleasant associations for the successful establishing of habits, re the interests of children at different age levels, from *Physiology* information regarding the effect of strong emotions such as anger or fear or fatigue on the digestive processes, from *Psychiatry* information and findings regarding the unhealthy emotional effects of fault-finding or blaming parental attitudes or too great a parental concentration upon the child, and from all these contributions, Mental Hygiene arrives at a practical method of food habit training that, while insuring the child's physical health, exercises desirable emotions in the learning process, helps the child establish his independence and preserves his Mental Health.

Mental Hygiene is "not a speciality confined within the province of mental disorder but a *life attitude* with a fund of useful information to make it practicable."*

*Grove and Blanchard: Introduction to Mental Hygiene.

Juvenile Diabetes

By I. M. RABINOWITCH, M.D., Director, Department of Metabolism, The Montreal General Hospital.

By juvenile diabetes, I mean diabetes mellitus occurring in children of fifteen years of age or under.

The incidence of this condition is, apparently, not very great. In the following table are recorded the annual admissions for diabetes at The Montreal General Hospital from January, 1923, to November, 1928.

Incidence of Juvenile Diabetes in the Clinic for Diabetes at The Montreal General Hospital from 1923 to 1928.

		CHILDREN	
YEAR	Total number of Diabetics	Number	Per cent of Total
1923	206	9	4.3
1924	184	12	6.5
1925	220	14	6.3
1926	296	10	3.3
1927	282	13	4.6
1928	271	14	5.1
Total	1,459	72	4.9

It will be observed that juveniles represent about 5 per cent of the total admissions. This incidence agrees fairly closely with that found in Joslin's Clinic at Boston, which was 5.7 per cent. How relatively low the incidence of juvenile diabetes is may be seen from an analysis of standard life tables. These show that children of 15 years of age, or under, represent about 25 per cent of large populations. From these premises it follows that the incidence of diabetes under the age of 15 is less than one-sixth of that obtained after that age. That the incidence of this condition is probably even lower is suggested by the fact that since the course of diabetes, in the absence of treatment, tends to be more rapid and fatal in children than in adults, relatively more children than adults tend to come to hospitals.

As to the cause, or causes, of diabetes in children, it may be said that very little is definitely known, though there is much speculation. Time does not permit a discussion of this phase of the disease. The purpose of this paper is to present the results of a study regarding the outlook of the diabetic child. Though it would be interesting to include the experiences of cases met with prior to the advent of insulin, because of the different methods of treatment, this, again, would be time-consuming and would serve very little for the present purpose.

In order to properly estimate the outlook of the juvenile diabetic, there are three factors to consider. Each of these is clearly recognised in practice and may best be defined in terms of the questions put to the physicians by the parents.

Shortly after a child is first seen in deep coma, the question invariably put by the parents is "Will the child live?" After the child has been brought out of coma and has lived

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for a short time as it improves in health, as its mental and physical states approach those the parents have been accustomed to before the child had diabetes, the question invariably put is "Will it eventually be possible to discontinue the use of insulin and if so, when?" Should the child be fortunate enough to be able to eventually keep the urine free of sugar and acetone bodies and the blood sugar normal, without the use of insulin, the question which comes sooner or later is "Will it always be necessary for the child to be on a special diet?" Stated in more technical terms, the three questions to consider are:—

(1) Is it possible to prolong the life of the juvenile diabetic?

(2) Is it possible to improve carbohydrate tolerance? and

(3) Is it possible to produce a cure?

In order to attempt answers to these questions, I purpose bringing before you the experience we have had with juvenile diabetics at The Montreal General Hospital since 1923. During this period seventy-one children were observed. This number does not include eight children who have been observed since the present investigation was made in November, 1928. Though the greater part of my remarks will be confined to our own experiences, it will not be because I do not recognise the probability of other clinics having met with similar conditions. I realise that a consensus of experience would be a more reliable source from which to draw conclusions, but there are valid reasons for confining my investigations to the limits mentioned.

Firstly, I intend to demonstrate the results of comparative studies made with reference to the influence of many variables on the course of the disease. Diet is one of these. Since in no two clinics is the dietetic treatment of diabetes *exactly* alike, by making use of the experiences of other clinics one would be introducing variables, the influence of which would be rather difficult, or I should say, almost impossible, to measure. The second and equally important reason is that we know the different periods of time for which the great majority of these patients have been under fairly constant observation. Having been under observation, we should have a fair idea as to whether they have or have not followed treatment. This, as is well known, is a most important factor to consider in the interpretation of results.

The answer to the first question, that is, "Can the juvenile diabetic be kept alive?" is the simplest and most obvious, and will, therefore, be dealt with first. The fact that a child may be brought into a hospital in coma during the night and the following morning may be found playing with its toys speaks for itself. Of our 71 patients, 16 were admitted in, or very near, coma, and of these 16 children, 14 are alive today.

One case particularly is worthy of note. This child, a girl of ten years old, was first seen in 1923. At that time she was in deep coma. Her home surroundings are not the most ideal, either with respect to hygiene or food supply. Co-operation on the part of her parents is practically nil. It is almost impossible, in spite of the efforts of our Social Service Department, to have the child follow treatment. On account of these conditions, the hospital is an attractive place, and she has been frequently there, her name being found nine times on our admission records. At five of these admissions she was in deep coma, and on four occasions very near it.

That the juvenile diabetic can be kept alive is still further demonstrated by the fact that of these 71 children admitted to our clinic during the last five years, 67 are alive. Of the 5 deaths, 1 was due to an accident and 1 to pneumonia.

The answer to the second question, that is, "Can carbohydrate tolerance be improved?" is also not very difficult. Proof of improvement of carbohydrate tolerance may be regarded as having been demonstrated by any one of the following results:—

(a) The child, having been found to require insulin, and having had it for a period of time, can increase the total caloric value, or the carbohydrate content of the diet and at the same time not increase the dose of insulin; or

(b) After having been proved to require insulin, and having had it for a period of time, the child can, without decreasing the carbohydrate or caloric content of the diet, reduce the amount of insulin taken. (If, when either the dose of insulin has been decreased and the same diet maintained, or the diet has been increased on the same dosage of insulin, the urine fails to remain sugar-free and the blood sugar normal, this is proof that no increase of tolerance has taken place); or

(c) The child, not requiring insulin, and having had its carbohydrate tolerance estimated, is found at a later date to be able to increase its diet, either as to carbohydrate or caloric contents, and at the same time fails to show sugar in the urine and keeps the blood sugar normal.

In the interpretation of the data obtained in such a study there are many variables to consider. It may, however, be stated here that unlike in adult diabetes, it can be definitely demonstrated that carbohydrate tolerance can be improved in children. Of the 71 children, all of whom required insulin on admission to the clinic, 26 have been able to reduce the dosage of insulin and 7 have discontinued its use entirely. These figures will be referred to again.

The answer to the third question, "Can present day treatment result in a cure?" cannot as yet be given except in the negative, at least from the experience of our clinic. There is, however, no reason for the answer to be emphatically in the negative. As a matter of fact, there are some encouraging signs to the contrary. Firstly, as in adult diabetes, there is no clinical or experimental evidence of an inherent tendency for the juvenile diabetic to get worse. Secondly, there is definite evidence that carbohydrate tolerance can be improved and, lastly, there is no proof, clinical or experimental, that insulin loses its potency in time.

A most important point to bear in mind is that there is no sharp line of demarcation between improvement of carbohydrate tolerance and cure. Since carbohydrate tolerance can be improved, it is essential to study the factors governing such improvement, and it is the results of this study which I regard as the most instructive of those which I wish to demonstrate.

A first glance at our records showed much confusion. In some cases it was necessary to increase the doses of insulin; in other cases it was not only possible to decrease the amounts, but to entirely discontinue its use. In other instances no changes were noted. It was also found that in some cases the children had gained weight; others lost weight; and in others there was no change. The same applied to the question of skeletal growth. In some cases the rates of growth were normal; in others they were increased; while in others the heights were stationary. A glance at the laboratory records also showed confusion. Judging from the blood and urinary data, the diabetes was kept under control very well in some cases; in others less so, and in others not at all. An analysis of our plasma cholesterol data, which we regard as very important from the point of view of prognosis, showed that in some cases the values were normal; in others they were below normal; while in still others they were markedly increased. In order, therefore, to obtain a clearer picture, it was necessary to assort the records as follows:

1. *Age:*
   (a) On admission.
   (b) At present.
2. *Date of admission:*
3. *Period of observation* (expressed in terms of months).
4. *Sex:*
   (a) Male.
   (b) Female.

5. *Body weight:*
    (a) On admission.
    (b) Classification on admission with respect to being over, under, or of normal weight.
6. *Dosage of Insulin:*
    (a) On admission.
    (b) Present dosage.
    (c) Classification as to whether the dosage was increased, not changed, decreased, or discontinued.
7. *Degree of Control of Diabetes Judging from the Laboratory Data:*
    (a) Urine sugar free: blood sugar normal.
    (b) Urine sugar free; blood sugar less than 0.18 per cent.
    (c) Glycosuria once a month.
    (d) Glycosuria twice a month.
    (e) Glycosuria once a week.
    (f) Glycosuria twice a week.
    (g) Glycosuria daily, but free at times.
    (h) Glycosuria persistent.

This classification with respect to the degree of control of diabetes may appear arbitrary, but in my experience has been found practical.

It is obvious that it is possible from a rearrangement of the above data to determine whether there is or is not any relationship between any of the factors mentioned and the course of the disease. The data were first arranged in order to determine whether there was a relationship between the control of glycosuria and insulin dosage. It was found that only those patients who kept the urine free of sugar, and the blood sugars normal or near normal, were able to discontinue the use of insulin. Of 28 patients who had to increase the dosage, 25 showed glycosuria at some time or other, and 21 had glycosuria more than once a week. This demonstration appears to me to be positive proof of the importance of keeping the urine sugar-free and the blood sugar normal. This, I may say, is contrary to the teaching of some workers in this field. This will be referred to again. From the clinical point of view no differences could be demonstrated between these children. All felt and looked very well. Clinically, it is today impossible to detect any difference between the child whose blood sugar is normal and whose urine is free of sugar, and the child who takes large amounts of food and insulin and has persistent glycosuria.

The data were then arranged to determine whether there was any relationship between body weight and insulin dosage, and here we note that the two conditions are related, and that allowing the child to become overweight interferes with improvement of carbohydrate tolerance. Of the 27 patients who became overweight not one was able to discontinue the use of insulin. Of the 44 children who were normal or under weight, 22 were able to decrease the amounts and 7 to discontinue its use entirely. Of the 7 who were able to discontinue the insulin, 5 were under weight. Clinically there appeared to be no difference between the children who had to increase the amounts of insulin and those who were able to reduce the amounts or discontinue its use entirely.

The data were then assorted in order to demonstrate whether there was or was not a relationship between control of blood and urinary sugar and body weight, and here the results were striking. Of the 27 patients who were overweight, only 4 kept their urine free of sugar and their blood sugar normal. Of the 44 patients who were either of average or below the average weight, 7 only had persistent glycosuria and 10 had sugar in the urine not oftener than twice a month.

The next step, the results of which are regarded as the most instructive, was an attempt to determine whether there was a relationship between the control of diabetes and the cholesterol content of blood plasma. At this point, it will be necessary to digress briefly upon the relationship between plasma cholesterol and diabetes in general.

Of all measures available for the estimation of progress of the diabetic a knowledge of the plasma cholesterol is, in my opinion, the best. Patients may, on discharge from the hospital, have urine free of sugar and normal blood sugar, yet may show plasma cholesterol values above the normal. The majority of such patients do not appear to be well. The slightest indiscretion in diet leads to glycosuria which is not readily controlled. Such patients are also more susceptible than others to infection and, in the case of adults, to gangrene. There is a definite relationship between duration of life and plasma cholesterol. If diabetics are classified according to the degree of control of glycosuria, one finds a definite relationship between the latter and plasma cholesterol. These data are based upon a study of two thousand blood examinations in 385 patients.

This demonstrates that as the diabetes is less and less controlled, that is, as glycosuria becomes more and more frequent, the plasma cholesterol increases. That these results are not accidental was shown in a statistical study of the average values recorded. For details concerning this statistical study, may I refer you to the original article (3).

In vew of these findings in adults, the same study was made with juvenile diabetics. The children were grouped in the same manner, and the average plasma cholesterol values were calculated for each group.

It is obvious that, because of the small number of patients in each group, limited significance must be attached to these average values. In order, therefore, to treat the data statistically, all the children were divided into two large groups, namely:

(a) those who had glycosuria; and

(b) those whose urine was sugar-free.

With this classification there were 20 in the former and 26 in the latter group. It was observed that there was a definite difference between average cholesterols of the two groups. The corresponding cholesterol values were 0.285 and 0.184 per cent, respectively. For the statistical proof that this difference was not the result of chance may I refer you to the original article (4). In other words, children with glycosuria, that is, children in whom the diabetes is not controlled, tend to have high blood cholesterol.

Further proof of this conclusion was sought from another point of view. An attempt was made to determine whether there was any relationship between plasma cholesterol and insulin dosage. For this purpose the children were divided into four groups, namely:

(a) those who have had to increase the dosage of insulin;

(b) those in whom the amount required when first seen has remained unchanged;

(c) those who were able to decrease the amount; and

(d) those who were able to discontinue its use entirely.

The average plasma cholesterol percentages were then calculated for each group. Again the number of cases corresponding to each group was small and in order to treat the data statistically they were divided into two large groups, as follows:

(a) those who were able to decrease the dosage of insulin, and

(b) those who were not able to do so.

The results of this procedure showed that there was a definite difference between the blood cholesterol values of the two groups. Statistical treatment showed that the ratio of the difference between the means to the probable error of their difference was 4.7. From this it may be calculated that the chance against the accidental occurrence of such a difference as found between the means was about 650 to 1. That is, it is certain that insulin dosage was related to plasma cholesterol. In other words, children with high blood cholesterols are, as a rule, unable to reduce the amount of insulin taken. Clinically, there appears to be no difference between those children who had high plasma cholesterols and those whose blood was normal.

This completes our investigation. From all of the above observations the following conclusions are drawn.

Conclusions

1. The outlook of the child suffering from diabetes mellitus, but properly treated, is not only good, but much better than that of the adult, since proper treatment leads to improvement of carbohydrate tolerance.

2. Proper treatment consists of:
(a) keeping the urine free of sugar;
(b) keeping the blood sugar normal; and
(c) preventing overweight.

3. The clinical picture (that is, the attitude, the expression, the colour and nutrition), is not a reliable index of the true progress of the diabetic child. It may be very misleading and should receive very limited consideration in the estimation of progress.

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Caesarian Section

By DR. JOHN J. MacPHERSON, F.A.C.S.

Caesarian Section may be defined as an obstetric operation for the delivery of a foetus by means of an incision through the abdominal and uterine walls. It is an operation having for its object the saving of two lives under adverse conditions, and was designed to prevent general peritonitis in neglected cases of contracted pelvis and to preserve the life of the foetus.

Previously to this craniotomy was the operation attended with the least risk of infection. No one wishes to perform such a cruel operation on a living child.

It was generally asserted that Julius Caesar was brought into the world by means of Caesarian Section and obtained his name from the manner in which he was delivered. This explanation can hardly be correct, as his mother, Julia, lived many years after her son's birth and besides, Julius was not the first of his name since there is mention of a priest named Caesar who lived several generations before. In the Roman law it was ordered that the operation be performed upon women dying in the last few weeks of pregnancy.

The history of Caesarian Section may be said to extend over three periods. The first dates from prehistoric times to the beginning of the sixteenth century. During this period, the operation was occasionally resorted to after the death of the mother, in the hope of saving the child, as the child often lives a few seconds after the mother's death.

The first recorded operation was performed in 1500 by a butcher by the name of Jacob Nufer, of Switzerland, who operated upon his own wife after she had been given up by midwives and barbers in attendance. The fact that the woman had five spontaneous labours later would go to show that this was not a true Caesarian Section but probably the simple removal of an extra uterine child from the abdominal cavity.

The uterine incision was formerly left unsutured as it was supposed that sutures would not hold on account of uterine contractions; results were that most of the women died from hemorrhage or infection.

Francois Rousset, a contemporary of Paris, wrote a treatise upon the subject in 1851, in which he gave the

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(A paper given before the Annual Meeting of the New Brunswick Association of Registered Nurses at Campbellton, N.B., September, 1930.)

histories of a number of Caesarian Sections, collected from different sources. His article had the merit of directing attention to the operation and to the possibility of performing it upon the living woman.

The first authentic operation was done in 1610 by Trautman of Wittenburg. During this period the uterus was simply incised and the child extracted; results were, as before, the woman died of hemorrhage or infection.

Sutures were first employed by Lebas in 1769, but did not come into general use until 1882.

According to Budin not a single successful Caesarian Section was performed in Paris between 1787 and 1876. He points out that out of 11 Caesarian Sections performed in the city of New York during that period only one patient recovered.

The third period began in 1876, when Porro advised amputating the body of the uterus and stitching the cervical stumps into the lower angle of the abdominal wound in order to lessen the danger of hemorrhage and infection. In 1882, Sanger of Leipsic showed that the uterine incision could be sutured with safety, provided the suture material was sterile. Since that time mortality attending the operation has been steadily reduced.

The Indications for this operation may be: Absolute or Relative. An Absolute Indication is the presence of some condition which renders impossible any other method of delivery, pelvic deformity, foreign growths obstructing the pelvic canal, cicatricial contraction of the vagina and carcinoma of the cervix or rectum.

The most common Relative Indications are a conjugate of 6 to 8 cm. or 2½ to 3½ ins. and also tumours which cause a moderate degree of pelvic obstruction. Also when the prometory of the sacrum is palpable per vagina by the tip of the index finger. A Relative Indication is the presence of some condition which makes doubtful the delivery of a living child by the natural passages. In some cases the question to be decided is whether Caesarian Section or one of the alternate operations will secure best results. (Pubiotomy, forceps, version, craniotomy.)

Deformities of the pelvis may be detected by external and internal palpation; and by measurements both external and internal of those diameters of the pelvis which are accessible.

For taking pelvic measurements, the examiner's fingers, a tape measure, and a pair of modified calipers, known as a pelvimeter, are usually employed. The pelvimeter was first devised in 1775.

When examination reveals the presence of an unusually large child, or the patient presents a history of previous difficult labours with dead children, Caesarian Section should be performed. In general, after consultation with another physician, he should leave the decision to the woman or her husband, having explained to them the nature of the case.

The best time for operation is within a week or so of the expected date of labour. The patient should be under observation for some days before the operation is undertaken. During this period the urine should be examined, the diet restricted and the bowels carefully regulated and general tonics given.

I shall cite briefly a few of the eighteen cases which I operated by this method, giving you only such history as is of interest.

1. A Primapara Eclampsia; 7½ months pregnant, with a rickety pelvis and a living child. Mother and baby made good recovery.

2. Patient with deformity of the perineum; in fact, hardly any perineum present. Had two previous instrumental births, having in each case a complete laceration of the perineum, and after second delivery,

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had to have a secondary repair with only fair results, and a vagina outlet that presented nothing but cicatricial tissue. Also had extensive albumenuria which necessitated special treatment. The third time I delivered her by Caesarian Section and tied off the tubes, as it was doubtful if a third complete laceration of the rectum could ever be dealt with satisfactorily, having already had three repairs for two complete lacerations.

3. A patient with a generally contracted pelvis who had given birth to three still-born children, all instrumental, with patient very ill for some time after delivery. I performed two Caesarian Sections at intervals of two years apart, on this woman, having a living child in each case; the last operation sterilising her by means of incising and ligating the fallopian tubes and burying stumps in the broad ligament.

4. Was called to hospital to assist another physician whose patient four years previously had given birth to a still-born child. High forceps. On this present occasion instruments were applied three or four times during the night, with unsuccessful delivery and a child still viable. I performed a Caesarian Section and, in addition, a sub-total hysterectomy. The reason for doing this hysterectomy was in case of infection from manipulation. The patient stood the operation well and mother and child made an uneventful recovery, with no marked degree of shock as one might expect under such conditions.

5. Patient, primapara, referred to hospital from country after being forty-five hours in fairly severe labour. Examination revealed os dilated about the size of a quarter. Head not engaged. Occipito, posterior position. History of several vaginal examinations by two different physicians. A Caesarian Section was performed on this woman. The uterus was not removed. Mother and child were discharged from hospital twenty-one days after operation.

6. Next was a woman of 44 years of age, admitted to hospital with a history of fairly severe bleeding at times for three weeks. Previously, she had twelve normal births. Pelvic examination revealed rigid os dilated about size of index finger, with placenta and lower uterine segment just palpable. From history and examination of the case, woman was seven months pregnant, showed very anemic condition, child viable. A Caesarian Section in this case was thought advisable on account of the condition of the cervix and fear of having excessive hemorrhage when dilation and version would be attempted. A Caesarian Section was performed. The woman was sterilised on account of age and number of children and also a fibrosis uteri. The child died four hours after delivery. The mother made a good recovery.

7. Patient, primapara, age 39, admitted to hospital with albumenuria which did not yield to treatment, showing clinical signs and symptoms of approaching eclampsia. She had a growth of a malignant nature of the vagina and two palpable fibroids of the uterus. A Caesarian Section was performed on account of vaginal lesions, albumenuria, fibroids, and age of patient. In addition to a Caesarian Section, two fibroids were removed. Patient was not sterilised on account of her condition under the anesthetic. Both mother and baby survived.

Eleven succeeding cases were done. Primiparas between ages of 33 and 40. Mothers and babies survived the ordeal and were able to return home after about 21 days in hospital.

Now I will describe the preparation and technique as it is carried out in our hospital.

The patient is admitted, if possible, two days before set date of operation, and about a week before the expected time of labour. The night previous to operation, the abdomen and pubes should be shaved and scrubbed and a sterile towel applied. A cathartic is given that night and an enema in the morning. The instruments required are the same as for an ordinary abdominal laparotomy and also those for hysterectomy, in case they are needed for uncontrollable hemorrhage, when a hysterectomy would have to be resorted to. Also an extra supply of tape sponges are necessary.

Three assistants are required. One, to give the anesthetic, one to compress cervix and control hemorrhage, and one to attend the child. Also two operating room nurses are necessary, one of these to look after sterilised instruments and ligatures and one to look after tape sponges.

The patient is then taken up to the anesthetic room and after being partially anesthetised, is catheterised and the vagina swabbed out with a 2 per cent. solution of iodine, and sterile gauze inserted in the vagina loosely packed. She is then wheeled across into the operating room and the abdomen is sponged off as quickly as possible with ether and two coats of 2 per cent. solution of iodine and then she is draped.

Anaesthesia is completed only when everything is set for the operation. Gas is the anesthetic to be preferred in these cases, but if ether is administered sparingly and there is no delay in the draping, the child will stand the ether all right.

The position of the patient on the operating table is slightly elevated, Trendelenburg position. Everything being set, a midline incision is made about five inches above the umbilicus and five below, extending through the whole abdominal wall. The uterus is delivered through this opening and is held in this position by the assistant, who controls the hemorrhage on either side, by firm compression. Pads are inserted behind the uterus and a vertical incision is made midline of the uterus, well towards the fundus and lengthened with scissors. If the placenta is on the anterior wall of the uterus, considerable hemorrhage will take place for a second or two until it is pushed aside and the foetus extracted. The cord is clamped with artery forceps, cut and handed to the assistant appointed to attend to the child, and recussitation carried out if necessary, all arrangements for this procedure having previously been made. The time allotted for this part of the operation should not be longer than 90 seconds.

The placenta and membranes are then expressed and it is very important to see that all the membranes or portions of same are removed and the os dilated in order to have good drainage. At this point one cc. of pituitrin is injected into the uterus. Hot sponges are applied to the uterus in order to aid contractions. Closure of the uterine wall is now carried out. 1st—No. 2 chromic catgut placed in large curved cutting needle, and inserted about ½ inch apart, and should include only the muscular coat of the uterus. After all these interrupted sutures are placed, the operator then proceeds to tie each individually. The peritoneal edges are then approximated by a second layer of interrupted No. 1 chromic sutures, placed at shorter intervals than the first layer. After sutures have been tied there should be no hemorrhage either from uterine wound or needle punctures. One cc. of ergot is given intra-muscularly in the arm at this stage. The abdominal cavity should then be sponged dry, paying particular attention to the renal fossae.

Having returned the uterus to the abdominal cavity and placed in proper position, the omentum is then to be brought down and carried behind instead of in front of it, in order to avoid omental adhesions. The abdominal incision is then closed in the usual manner and a surgical dressing applied. The vaginal gauze is then removed and a vulvar pad applied.

After Treatment—After the patient is returned to her room, before coming out of the anesthetic, a large rectal saline is usually given. The after treatment is much the same as any abdominal operation During the first 24 hours, morphine grains, $\frac{1}{6}$ every 4 fours should be given. The child may be put to the breast after 24 hours. Special care should be given to the vulva in order to prevent infection of the vagina.

The abdominal suture may be removed on the 10th day. The patient may be allowed out of bed on the 18th day and discharged from hospital on the 21st day. An abdominal support should be worn for about six months after operation.

Prognosis—The mortality varies at the present time from 2 to 14 per cent., depending on the class of cases operated on. This marvellous diminution in mortality is due to several factors; primarily, of course, it must be attributed to the ever increasing perfection of aseptic technique. At the same time careful examination of the pelvis before labour and the determination to operate while the patient is in good condition, instead of only after the failure of other methods of delivery, have contributed markedly to the improvement.

The number of Caesarian Sections that can be performed on the patient are two or three, with a moderate degree of safety on the part of the mother; although as many as five are reported to have been done. The reason for this is that with every Caesarian Section the uterine wall is weakened and rupture of the uterus may occur during pregnancy. Besides, abdominal adhesions in general increase with each operation, and we all know that it is unwise to open an abdomen more than three times, unless it is a case of absolute necessity.

Florence Nightingale Association Hold Farewell Dinner

The dinner notices read as follows:

> "The final meeting of the Florence Nightingale Association will be in the form of a dinner at the King Edward Hotel, Monday, January 26th, at 7.30 p.m.
>
> "Help to make this farewell evening a success by being present in your gayest mood and with your brightest smile."—(Music and Drama).

A very delightful dinner took place in the Blue Room of the King Edward Hotel, Toronto, on Monday evening, January 26th, that closed, in an atmosphere of music and drama, the life of the Florence Nightingale Association of Nurses in this city.

The room in which the dinner was held, with its lovely colour enhanced by shades of rose and gold, was most attractive. Two long tables ran the length of the room, with the head table across the upper part. Fresh and fragrant spring blossoms—daffodils, tulips, narcissi and fresia—together with the gowns of the guests, made a pleasing picture. Animated faces and beautifully coiffed heads were in evidence, and the dinner itself was most pleasing and attractively served.

Miss Bessie Hutchinson, the President of the Association, presided at the dinner, and at her right hand, as guest of honour, was Mrs. Goodson, formerly Miss Brent of the Sick Children's Hospital, who had a prominent part in forming the association twenty years ago. At Miss Hutchinson's left was Miss Wardell, well known here and throughout Ontario for her long connection with the Central Registry in this city and who was the first secretary of the association, an office she held for ten years. Others at the head tables were: Miss Jean Gunn of the Toronto General Hospital, and Miss Edith Campbell of the Victorian

Order of Nurses. About forty-five guests were present and a pleasant feature as the guests were seated was the introduction of each guest by her right hand neighbour. Her name, school, position, and other interesting details were given, so that everyone was so well acquainted with each other that an air of informality was evident, and this was enhanced by the delightful music provided by Miss Billy Bell, who sang, and Miss Henson, her accompanist. They were so generous with their music, and so clever in their choice of songs, and so informal in their methods, that they drew the guests close to each other and to themselves.

The writer has been at many dinners of "Women without men," and more particularly nurses' dinners, but does not remember any where there was so much sparkling conversation, laughter and enjoyment.

Miss Jean Gunn, of the Toronto General Hospital, was the speaker of the evening. In a witty address, she reviewed the history of the F.N.A. since its organisation in March, 1910, until 1930, when it was decided that it was no longer necessary to have an association of this kind in Toronto. The address will appear in an early issue, therefore it is not necessary to mention it further except to say that it was most interesting and complete.

Mrs. Goodson then spoke briefly, and was followed by Miss Ethel Greenwood of the Victorian Order of Nurses and Miss Rubena Duff of the Women's College Hospital, who put on a skit entitled "The Beginning and the End." The skit was in two scenes, the first scene taking place in the old General Hospital on Gerrard Street in 1910, in which Miss Greenwood wore the uniform of her school (New York Hospital) of twenty years ago, and Miss Duff the uniform of her school (St. Luke's Hospital, Utica, N.Y.), of the same period. They wore wigs—Miss Duff's auburn and Miss Greenwood's black—to restore the youthful lustre to their hair. In the second scene they were dressed in their usual costumes of 1930, the scene taking place in the Women's College Hospital—Miss Duff in her regulation white uniform and Miss Greenwood in the street costume of the V.O.N. During the skit a good deal of history both grave and gay was reviewed. The "actresses" (?) indulged in gentle satire and reminiscences. There was considerable merriment, and from the way it was received there was no doubt of its success.

There was, amidst the laughter and applause, a note of sentiment, and of sadness, too. During the twenty years of its existence, the F.N.A. numbered on its list of members some of the most outstanding women in the profession in Toronto. Some of these are occupying prominent positions elsewhere in Canada or in the United States: many remain in Toronto: some have gone from this life.

It was impossible not to remember the absent faces and not to think of the happy associations during so many years centred around the old nurses' club on Sherbourne Street. It was fitting that the close of the "Flossies" should come this way. The association passed into history with song and laughter, with head erect and all its flags flying.

At the close of the dinner, Miss Harriet Meiklejohn moved a warm vote of thanks to those who had provided the entertainment and to those responsible for the arrangements.

Some of those present at the dinner were as follows: Miss Bessie Hutchinson, Miss G. Colborne, Miss Jean Gunn, Miss Helen Locke, Miss Wardell, Mrs. Goodson, Miss Edith Campbell, Miss Harriet T. Meiklejohn, Miss Wilkinson, Miss Ruby Hamilton, Miss McEwen, Miss Ethel Greenwood, Miss Barbara Ross, Miss Violet Carrol, Miss Zara Price, Mrs. Ena Paterson Manning, Miss Luxon, Miss Louise Reid, Miss Dorothy Reid, Mrs. Edwards, Miss Mary Keith, Miss Menary, Miss C. McLennan, Miss Lily Delaney, Miss Mole, Miss Hopkings, Miss Helen Campbell, Miss Jean Campbell, Miss Mary Benedict, Miss M. Lynch, Miss W. Murray, Miss Secord, Miss Mary Smiley, Miss M. Watt, Miss Greenaway, Miss Laura Conlin, Miss Louise Blackmore, Miss Rubena Duff, and others.

—R. D.

Mother Monica Passes Away

On January 23rd, in her 80th year, Mother Monica, for many years the Superintendent of St. Joseph's Hospital, Port Arthur, Ont., passed away quite suddenly.

Mother Monica was the pioneer superintendent of the pioneer hospital at the head of the Great Lakes. She was one of a small band of five Sisters who left Toronto in 1881, going to Port Arthur to start a new Roman Catholic Mission. A school was first started. In 1883 the Sisters were asked to start a hospital, and in 1884 a small two-storey building was constructed—the nucleus of the present St. Joseph's Hospital. Mother Monica was in charge. The need of a hospital was great. There were no hospitals between Winnipeg and Toronto. The Canadian Pacific Railway was only in the course of construction at this time.

The pioneer work of those early days in the 'eighties and 'nineties sounds unreal to the present generation of nurses. Mother Monica and her Sisters often assisted doctors at night operations, using lamps and candles for illumination. Water was brought daily in large barrels. Stoves were used for heating purposes. But the modern soon replaced these primitive methods and by the end of ten years the more strenuous years of pioneer work had passed.

Financing was another great problem, and Mother Monica and her Sisters made many hazardous trips up and down the line of construction camps, collecting money to carry on their work of service. Many visits were made to hospitals in the East and in the United States for the purpose of keeping in touch with modern advances and improvements in hospital work.

Additions were made to St. Joseph's Hospital several times during Mother Monica's long period as Superintendent, until the last building brought the capacity up to 200 beds. During all these years, Mother Monica was always known to make her daily rounds and visit each patient for a few minutes. Her great human sympathy was very remarkable and those who knew her feel that a very good and great woman has passed away from our hospital activities.

Nurses, Stay Home

Think twice before spending your money and energy in seeking a job away from your home community, urged Colonel Arthur Woods, chairman of the President's Emergency Committee for Employment, in a recent radio talk. An excellent piece of advice just now, and particularly applicable for nurses. Leaders are recommending that for the next months, at least, you stay in the locality where you are known by doctors, hospitals, registry, and patients. Do not go elsewhere in the expectation of finding something better to do. Almost certainly you will meet in the next town conditions similar to your own, of a decrease in the number of calls for nurses over that of the past several years, and an increase in the short-duration call of from one to three days.

We call the attention of nurses of other countries, and of our neighbours in Canada, to this situation, urging that they consider it before deciding to seek their fortunes in the United States. The present unemployment peak, especially in private duty, undoubtedly would be a serious deterrent to the foreign nurse trying to establish herself in this country.

(January, 1931, Bulletin, American Nurses Association.)

Nursing Sister Peggy Doherty

MRS. HERBERT AVERY

A flag-covered casket borne to the nursing sisters' section of the soldiers' plot in the Edmonton cemetery by members of the Canadian Legion and lowered into the grave as the Last Post sounded ended the earthly life of Nursing Sister Peggy Doherty. The pallbearers, one by one, placed their last tribute, blood red poppies, on the casket as the journey's end was reached.

The Requiem Mass was sung at St. Joseph's Cathedral by Rev. Father Murphy, prior to the graveside service, members of the Overseas Nursing Club and many of the medical profession attending.

Mrs. Herbert Avery's life, described by her fellow nurses as an adventure in friendship and service, was marked since the close of her nursing career by letters that have come to her from grateful former soldier patients all over the world. During her distinguished service overseas she was entertained by Princess Patricia, the Hon. David and Mrs. Lloyd George and other noted personages.

Leaving Ireland in 1913, Peggy Doherty trained at the Polytechnic Hospital in New York, joining her mother in Edmonton on graduating in 1915, when she enlisted with a unit of twelve nurses who were sent to London under the C.A.M.C. and detailed from there to duty. Returning to England after the Armistice, she was on duty at Basingstoke Hospital until she returned to Canada in June, 1919, marrying Herbert Avery in 1921. Mr. and Mrs. Avery moved to the coast in 1924, returning to Edmonton in 1929. For many months previous to her death Mrs. Avery suffered greatly.

Miss Mary McCuaig Receives Appointment

Miss Mary McCuaig, until recently nurse in charge of the Edmonton Branch of the Victorian Order of Nurses for Canada, has been appointed Western Supervisor of the Order, replacing Miss Nan McMann, whose resignation, owing to illness, was regretfully accepted last fall by the National Office.

Miss McCuaig is a graduate of the Toronto General Hospital School for Nurses, and served overseas from 1915-1919. Following a period of institutional work she was granted a Victorian Order scholarship for a year's post-graduate work in public health nursing at the University of Toronto. Upon completion of this course she took charge of the Lunenburg Branch of the Order, being later transferred to Edmonton.

In addition to high professional qualifications, Miss McCuaig brings to her new work a love of the West and an understanding of the West which will help to make her appointment a very happy one indeed.

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Department of Nursing Education

National Convener of Publication Committee, Nursing Education Section,
Miss ANNIE LAWRIE, Royal Alexandra Hospital, Edmonton, Alta.

How May the Habit of Study be Encouraged in the Student

By EUGENIE M. STUART.

In hoping for any measure of success in this project, the health of the student must be a primary consideration. Unless her physical condition is such that she may concentrate on the subject, the study hour might better be abandoned; fatigue can seriously affect the attitude of the student to the study. The teacher must decide the capacity of the class, and the amount of study which she may reasonably expect from the individual members.

External conditions, such as temperature of the room, suitable ventilation, proper lighting and accommodation, must be considered. Formation of the habit of studying in familiar surroundings—at the same desk, in the same chair—should be encouraged. A prominent psychologist tells us that for many years he has studied with "The Fall of the Roman Empire" on his desk, and that, although he does not open this volume, he cannot concentrate without it.

Readily accessible material is another important factor in establishing good practice. Whenever possible the library should be a comfortable room where the students may come—not necessarily in uniform—and utilise their spare time. The library being open to the students suggests that freedom and ease for study which is essential to all pupils, especially the student nurse. Where a library is conducted on the basis of a lending library it cannot also be a reference library unless a sufficient number of books be provided to fill the requirements. Again, here one nurse must act as librarian and this duty consumes valuable time. Where books and magazines are locked the habit of study is discouraged; considerable time is lost gaining access to materials. The results of an open, comfortable library are readily seen in the use made of the library.

Up-to-date text and reference books, current literature and magazines should be provided. Not alone should books be provided, but they should be catalogued in such a manner that each student may easily find the reference required. Mazagine articles should also be filed under general headings. In larger hospitals where the library may be some distance from the wards in which practical work is carried on, a small ward library is very helpful and convenient. The standard text books, and one or two text books dealing with the specific condition treated in that department, should be included in the library.

Our careful consideration should next be given to the question, "Does the student know how to study?" Students vary greatly in their ability not only to use a text book or a reference book, but to recognise and use other sources of available help. They can be taught to draw upon their own experience, from facts which are all about them in the open book of the wards, from the experience and example of teacher or fellow-students, from charts, magazines, state or municipal bulletins, and museums. Students must be taught how to use the text books, the use of the index and table of contents, the general plan of arrangement into large topics and subtopics, the principles of presentation and at the same time the fallibility of all text books.

The student must be made to feel the need of new material; that is, we must set before her some worthy interest or motive. Once the student realises this need she will exert an effort on her own part to acquire that material. Definite assignments, either ward or class room, provide the student with a motive for study. Assignments should be most explicit and detailed in the class where the pupil is just learning to use text books. It is important to remember here that if, in our enthusiastic desire to broaden the student's viewpoint and to put them in touch with a wide range of resources, we make our assignment too long or too difficult for the time available or for the ability of the student to accomplish with satisfaction, we will defeat our own purpose.

In the assigning of any particular study three considerations must be borne in mind: (1) interest values, (2) content values, (3) procedure values; and each of these values is equally important and must be judged on this basis in the choice of a project.

The Case Study is an assignment from which the patient and student derive great benefit. The headings given in the Case Study Outline are not intended to suggest that the student gain this information by asking questions—just getting so many facts. On the contrary, these headings are only a guide to the information which would be helpful in understanding the needs of the patients: they are meant to stimulate interest and direct keen observation, teaching the students to interpret what their observations reveal, with a view toward more intelligent and sympathetic nursing.

Again, the student should be made to realise that to teach is one of the most important duties of all nurses. She will then feel the need of the knowledge which will enable her to do so. It is not expected that the young, inexperienced nurse will understand fully treatments, procedures, etc., as discussed in the class room. This can only come with a thorough knowledge of other subjects and a gradually widening experience. This experience, however, will be of little value without a knowledge of what to observe, how to observe, what symptoms indicate improvement, what the reverse, which are of importance, which are of none, and without a frequent reference to and checking up of experience with the text.

The asking of questions relating to the patient should be encouraged and the head nurse or the supervisor should herself be so familiar with literature regarding the question that she may direct the attention of the student in the proper direction.

The showing of films as a means of arousing interest and stimulating study is important. The film "The Development of the Connaught Laboratory" is not alone instructive, but it awakens an interest in Professor Fitzgerald's recent volume "Practice of Preventive Medicine."

In the teacher's reception of the efforts of study by the pupil, encouragement and cheerfulness are keynotes. Honest, efficient work on the part of the student should be candidly and duly commended. Criticism should be positive rather than negative, constructive rather than destructive.

In closing, may I quote Dr. Osler, who has said, "To study the phenomena of disease without books is to sail an uncharted sea, while to read books without patients is not to go to sea at all."

Department of Private Duty Nursing

National Convener of Publication Committee, Private Duty Section,
Miss CLARA BROWN, 153 Bedford Road, Toronto, Ont.

The Significance of Registration for Nurses

By MISS E. FRANCES UPTON, Registrar and Executive Secretary.

"Every person," says a celebrated document, "has an inalienable right to life, liberty and the pursuit of happiness." Nevertheless, this right has been subjected to certain restrictions. Every individual has the right of life, but not to such liberty of action as to give the right to injure a fellow-being or to so conduct the pursuit of happiness as to inflict harm on others.

"A man who lives on a desert island has unlimited and undisputed rights and is a law unto himself. Such a person is the only individual who enjoys the questionable privilege of absolute freedom. The moment a second ship-wrecked sailor lands on the shore, the rights of the first comer are no longer paramount, and he can secure and perpetuate the former freedom only by force or murder."

The existence of a community implies the existence of law; all laws contemplate the existence of large bodies of individuals living together, whose relations to one another require regulation. The greater the complexity of the community and the diversity of its pursuits, the more necessary does it become to define and limit the rights of the individual, so the community must interfere on behalf of communal welfare and restrict unlimited liberty, which can be the undisputed possession only of a Robinson Crusoe, since what is liberty in a recluse becomes license in the smallest hamlet.

Very early in our present civilisation, to prevent the debasement of a precious metal, governments established a standard of fineness which was maintained by law. Thus in England what is called a "hallmark" affixed to a piece of silverware, establishes beyond question the rates of alloy and the quantity of precious metal. In this country, the same protection is given by the word "sterling", which is in a like manner a guarantee of quality and a measure of value. The improper use of either emblem is punishable by fine and imprisonment. Such laws protect the public from imposition, and the honest silversmith from the competition of the dishonest. If it were not for this protection, the temptations to fraud are so great that manufacturers would soon vie with one another as to how little silver they could put in one article and have it pass muster as silver. This was one of the earliest forms of supervision, and was in fact a sort of registration of the finished product.

Registration and the issuing of licenses to practise any particular trade or profession are, in fact, "hallmarks" of value of the education which the individual has received and his or her fitness to do business for the public.

As the complexity of our communal life increased, it soon became evident to the law makers that such governmental supervision would have to be extended to many different vocations, because their pursuit by incompetent persons would eventually become a menace not to one or two individuals, but to the public at large. For instance, it is manifestly improper to allow an engineer or pilot to take part in the

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(Read before the Private Duty Section A.R.N.P.Q. at their regular meeting on November 4th, 1930.)

management of a vessel designed to carry passengers unless competency has been clearly proved, since the incompetency of either involves the possibility of great loss of life. Then the state assumes the right to restrict the occupation of engineer and pilot to such persons as are able to pass a suitable examination and can show that they possess the necessary qualifications.

The same principle has been extended to many other trades, where a failure of due knowledge involves risks to the public health or welfare. In the profession of law, it has long been the rule that an attorney must pass an examination ordered and conducted by the Court, before he is allowed to practise, and this, no matter how long has been his experience in a law office.

Up to not a very great many years ago there were no legal restrictions placed upon the practice of medicine, and it was only necessary for a man to call himself doctor to enable him to practise on the credulity of ignorance of the public. The country was flooded by "quacks" of all sorts. The Indian herb doctor with his long hair and broad-brimmed hat and a mixed stock of various "Yarbs" and impudence, flourished exceedingly, and wandered about the country greatly to his own profit, and to the delusion of countless dupes. Every country fair was a camping ground for unnumbered "fakirs" with all sorts of remedies for all sorts of ills.

The patient always made the diagnosis, and the "quack" made his remedy fit the disease. It soon became evident that it was a manifest absurdity to enforce an examination on trades like the engineer and pilot and yet permit hordes of quacks to perambulate about the country and prey upon the distresses and ignorance of the community. Thus it was, no doubt, a source of great satisfaction to all medical schools when the Medical Acts which are in force today became law. Medical registration is now the "hallmark" of fitness. The present Medical Acts not only prevent the fraudulent use of the title "Doctor," but prevent persons whose lack of education unfits them for habits of study from entering a medical school.

That this has resulted in elevating the general standard of the profession no one will doubt. It has relieved the doctor of the illegal competition of persons who have put neither time nor money into an education for the purpose of properly qualifying themselves. The advantages of medical registration to the public are self-evident: the State has taken upon itself to see that all persons admitted to practise have the necessary qualifications.

Regarding nursing legislation, this is not a sudden development; it is the natural culmination of the work which Florence Nightingale began when she started with her band of women for the Crimea. Even her far-reaching insight could not foretell the magnitude of the change she was instituting. Her dauntless courage and unfaltering belief in the sacredness of her calling gave her the incentive for a work the results of which we are beginning to realise. Today, the whole nursing world is concerned with the advancement and betterment of nursing standards, and such things can only be achieved through state registration of nurses, and by the combined efforts of all registered nurses.

If the public needs to be protected from the quack medicine man, is it not equally important that it be saved, and the nursing profession protected, from the possible mistakes made by the woman who, without having passed within the doors of a hospital even, will don a white uniform and call herself a nurse.

Surely the "Sairey Gamps" have had their day? They did their best, and we believe that some of them were faithful old souls, but the modern methods and modern medicine and surgery have been made possible by the modern nurse. Read what some doctors have said: "If doctors were forced to relinquish all methods of therapy except one, I think that one would be good nursing." Another, "Three forces have united to place the science and art of medicine on its present footing: Anaesthesia, the Training School for Nurses, and Bacteriology".

Good nursing is the outcome of good nursing organisation, and the first signs of the dawning of this group consciousness in nurses were shown about1898. The first evidence appeared in the organisation of Alumnae Associations. "To a woman the collective good is always more important than the individual good; she must think of the welfare of all her children, not of one; she must recognise the whole, rather than a part. To women team work is all important."

As opportunities for intercourse with each other increased, with the growth of their numbers, some nurses during these earlier days united primarily to keep in touch with their own schools. They visioned the advantage to be gained by broader contacts. These small alumnae groups grew in size and number, and then the national organisations developed out of a union of scattered groups.

The aims of union to any body of people are: (*a*) strength to accomplish projects for betterment; (*b*) mutual protection from adverse influences; (*c*) the moulding of ideals.

South Africa was the first country in the world where nurses were able to obtain registration; this took place in 1891. Registration was first advocated in the United States of America in 1899, but the first bill was not passed until 1903, in North Carolina. The nurses of England went through a long struggle known as the "Thirty Years War" before they obtained their registration. The nurses of Finland have carried on their struggle over twenty-five years, and finally succeeded in obtaining their registration in 1929.

The nurses of the U.S.A. have registration in 48 states and the District of Columbia. There is no nurse registration in the State of Nevada, as there are no nursing schools in that state. The American colonies of Hawaii and Porto Rico have their nurse registration laws.

The first province in Canada to secure registration for nurses was Nova Scotia, in 1910. Manitoba followed in 1913, Alberta in 1916, Saskatchewan in 1917, British Columbia and New Brunswick in 1918, Quebec in 1920, Prince Edward Island in 1921, and Ontario in 1922.

What is meant by nursing registration? Registration is a process by which the public and the nurse are protected by law from those who cannot come up to a standard set by the state. By the registration system, schools are legally accredited only when they conform to requirements set by the law. Unless so accredited, their graduates are not permitted to be examined for R.N. certificates.

Reciprocity is an arrangement of the law by which a nurse registered in one state, province or country may be given authority to practise under the laws of a second state, province or country without examination.

Nurse registration "Acts, Decrees or Arrets" have been passed in thirty countries of the world, covering ninety-five provinces or states. The laws of these countries differ in many ways and degrees, and the administration of these laws has been placed in various hands.

Very few if any groups of nurses in any corner of the world are quite satisfied with their laws, yet much has been accomplished with regard to nursing progress and elevation of nursing standards during the thirty-nine years in which these registration laws have been made.

One has only to live but one short week, however, in any large city and come in contact with the daily activities of our nursing world, to realise that we have only begun.

Nursing laws have been made all over the world, thanks to the efforts and strenuous labour of our highly respected and internationally known pioneer leaders. These laws were made after much deliberation and careful consideration of the many points concerned, because there were many workers in the field who had contributed considerably towards the welfare of the various communities in which they lived, but whose educational qualifications did not come up to present-day standards and demands and for whom protection must be provided.

Registration has therefore set the minimum standard of education for nurses, and nurses are accepted on this standard: below this we do not recognise the nurse as such.

To improve our laws and make them worthy of professional status, is our job—we, the nurses of today, have in our hands the moulding of the nurses of the future. We must raise our nursing standards and demand that our educational requirements shall be such as will place our schools on a sound professional basis. The present-day needs must include a stimulation of our professional responsibility.

Legislation for nurses places in the hands of a given group the control of nursing education in a given community. It provides, through organisation and membership fees, the machinery whereby data is collected, schools inspected, comparisons made, standards elevated and research carried out for the betterment of nursing in that community.

We must educate the public to know the value of a highly qualified nurse, and what to expect from her. To produce such a person we must see to it that schools are conducted only in hospitals that are worthy; that these schools are conducted according to set standards; that our nursing instructors are better qualified than formerly for the task in hand, and that our administrators are qualified for leadership in every sense of the word.

What then do we need to do? To establish a recognised standard of professional education? We cannot establish our highest standards—only a fair general average, at least at first. Our highest present standards are the result of special intelligence and special advantages, all have not the same, and it would be no more reasonable to expect all to suddenly conform to the highest than it would be to expect the bread to bake without being long enough in the oven. We must first have the higher education and then the law to protect it. The one thing that is needed first, before we can expect good legislation, is a good technical education.

We have a nursing registration law in each province of Canada; none are even yet approaching what they should and no doubt will be, but they are the thin edge of the wedge, well established, and our duty now is to proceed slowly but surely to raise them. We cannot succeed, however, until every nurse in our country who is eligible for registration avails herself of the honour and flies her true colours.

We are at present, in our City, much concerned with "Made in Canada" goods, and as registered nurses we should concern ourselves with the production of "Made in Canada" nurses, that they may be the best which can be produced, and which will meet Canada's needs.

At present, we share the title "Nurse" with all types of persons, but we share the title "Registered Nurse" only with those who come up to an educational standard set by the law—the law made by our nurses.

In the early days, Mrs. Bedford Fenwick said, "the nurse question is the woman question pure and simple, and we can only secure professional enfranchisement through registration and self-government."

We regret to admit that there are many nurses in our midst, who, possessing the qualifications for registration, through indifference or petty economy do not avail themselves of the distinction and thereby signify their willingness to share the responsibilities of our profession, and to these may I be permitted to quote Emerson, who said: "Human character evermore publishes itself. The most fugitive deed and word, the mere air of doing a thing, the intimated purpose, expresses character. If you act, you show character; if you sit still, if you sleep, you show it. You think because you have spoken nothing when others spoke, and have given no opinion . . . that your verdict is still expected with curiosity as a reserved wisdom. Far otherwise; your silence answers very loud. You have no oracle to utter, and your fellowmen have learned that you cannot help them; for oracles speak."

Before closing may I say a few words on what we may term the ethics of registration. First of all, it has been proved beyond a doubt, that registration is a good and desirable thing, and that every nurse who is eligible for such distinction and protection, should avail herself of such. Secondly, after having obtained the honour it should be the desire of each nurse to hold it by living up to the standards set and by renewing her vows, so to speak, for without renewal fees the machinery cannot function and our cause is lost.

Lastly, it should be the desire of each registered nurse, to understand, to some degree, the problems confronting the group in which she is carrying out her chosen work, therefore she should seek membership in this group, whether it be near home or in a foreign land, and to secure such membership it is necessary that she make application for registration wherever she serves.

This is a point not thoroughly understood by all nurses, and one upon which too great stress cannot be laid. It is absurd to think that a nurse who is registered in Quebec, for instance, should expect to practice under the protection of the law of British Columbia or vice versa, without first ascertaining whether or not she is desirable in the new community, or eligible for recognition with regard to registration. By seeking registration in a given community, you indicate your desire to conform to local standards, and place yourself in readiness to help solve the local nursing problems.

To assist with the development of our professional responsibility, we should keep ourselves in touch with the nursing affairs, problems, and progress in other lands, and in other parts of our own land, and to do this we should subscribe to and read our own national nursing magazine, "The Canadian Nurse," "The International Nursing Review," and other nursing journals if possible. On account of the variety of standards and requirements for registration on this Continent, there is no such thing as "Blanket Reciprocity" between provinces and states, each application for registration by reciprocity must therefore be considered on its own merits.

Read, read, and then read some more. We have many writers among our North American Continent nurses whose ideas are sound and can inspire one to higher and bigger things, and I feel certain that none of them will mind if I especially recommend to you the works of Miss Adelaide Nutting.

Department of Public Health Nursing

National Convener of Publication Committee, Public Health Section.

Rural Fields

By EILEEN WRIGHT HAMILTON, Preeceville, Saskatchewan.

Who wouldn't be a Victorian Order nurse in the city?

Busy office, companionship, neat list of calls, baby clinics, pre-natal visits—that happy busy routine we all have known and loved. But then, who wouldn't be a Victorian Order nurse in a rural field; although the story I tell is so far removed from that of the typical Victorian Order branch that it is hard to realize that the same organization directs the two types of work, each to its separate need.

A UKRAINIAN HOME

My work embraces the usual Victorian Order programme within the confines of the Preeceville municipality in Saskatchewan, and includes as well the school inspection in the area. For this latter service the Department of Health of Saskatchewan supplies a Ford coupe and pays all expenses. Headquarters are in each of the two villages of the municipality—Preeceville and Sturgis. The nurse moves every two months and thus knows intimately conditions in both towns.

I might quote statistics of visits made and clinics held, but possibly the nurse from the city would be more interested in the recounting of actual trips made—the joys and sorrows of the daily routine in a rural district.

There was the time I was called to minister to the needs of Bill Black. My directions were explicit. "Go till you reach the Stenen road, follow it eighteen miles north, and there in Bill's own neighbourhood get directions for the last two or three miles." What could be simpler? Making sure the tank was full of gas and the oil all right, I set off at once. Here let me pause to give a word of advice. Should you find yourself in a rural district, never start *anywhere* without making sure your car is oiled and greased and the tank full. You never know where you will go before you get through with your trip, and you do not know with certainty when you will arrive home.

Reaching the Stenen road, I set my trip tally, the better to know when the eighteen miles had been covered. At first a pleasant road on which good speed was made. Then deep into bush country, roads getting rougher and speed slackening. At the end of eighteen miles I had left the farm homes behind and was deep in the bush. Nowhere was there anyone to ask where Bill Black lived, so I "kept on going."

Finally there appeared a clearing, a front yard full of cabbages and a small sod dwelling. At first I saw no signs of life, but as I came around the corner of the house I saw a woman using a hoe. She was not working in her garden. She was using the hoe to draw her bread to the front of a huge clay oven. She gave no sign that she had seen me until sixteen beautiful loaves were lined along the shelf outside. I had long since learned not to push matters, so I waited. After a discussion on the merits of brown bread, in which the woman took no part, I inquired for Bill Black. An eloquent shrug and hand spread conveyed her complete lack of knowledge on the subject. I went on, wondering how much good my oration on bread had done.

Next I met a team and wagon. I hailed the driver and inquired for Bill's residence.

"Yes. Him live by me."

"How far?"

"Ten mile."

With more explicit directions I drove on, and for another hour, during which I went steadily forward, the elusive Bill remained ten miles away as often as I inquired.

During this time I was by no means travelling due north. I turned west to circle a slough, east because the road did. Once I came to a corduroy road, which as you know, is built of poles about eighteen inches apart to give bottom to the slough road. Over this I wormed my way slowly. Smoke from bush fires was smarting my eyes, but I kept them carefully trained on the poles close in front of the car. I was thinking of the possibility of a broken spring, when suddenly I stopped the car with a gasp. There, just a few yards ahead, was a great hole where a plank bridge had burned out. I dared not drive into it and hope to drive out on the other side. It was hopeless to try to turn off just there. Have you ever reversed a car over a corduroy road where a foot to either side meant a sudden downward plunge? Need I say that at the first safe-looking spot for a descent I took to the slough. There was no water in it, but the ground was very spongy. Thanks to a light, powerful car I reached the far side safely, and after three more miles of bush trail I halted in Mr. Black's front yard.

It was a case of pneumonia. An hour later I left him comfortable and happy again.

Once outside I decided there must be some shorter way to Sturgis. One of the boys piloted me three miles through the bush where there wasn't a vestige of a trail. We just followed hay swamps. Then a neighbour directed us for another two miles. Following a trail we had reached, I finally came to the Woodlight school, from which I readily found my way to Sturgis, where I arrived at four p.m. Perhaps my day was wasted—perhaps not for Bill, who had spent long days waiting for the nurse and the relief she brought.

Our new Canadians are grateful for our care and are always ready to offer food and rest, or guide us for miles. One cold night I came out and found all the bedding a family possessed piled high over the radiator of the car. I was profuse in my thanks, although there was a goodly supply of anti-freeze in the car.

What a boon a car is to a rural nurse! There are times, however, when my little runabout won't fill the bill, like the night we went to Glenelder for Steve. When I first heard of Steve he had been lying for over a week with a badly broken femur, and because the roads were in a terrible condition, and the distance very great, no one would undertake to remove him to hospital.

The Preeceville Baby Clinic was in progress when I learned of Steve's condition, so the moment the hall was cleared I set out at once for one of my never-failing friends who owned a truck.

A short explanation, a hurried supper and we were away. While we stopped in Stenen to gather up a few splints, bandages, etc., the driver set the trip tally.

Such roads as we travelled! Miles stretched behind us and darkness set in. Finally Steve's little home in the bush came in sight.

We found Steve, a poor old man over seventy years of age, suffering intensely. We hastened to do what we could to make him comfortable. We had hoped to move him, mattress and all, into the truck, but there was a complication. How to get a four-foot mattress with its suffering burden through a two-foot door! I turned to my cheerful friend who had made the rescue party possible.

"Have you ever constructed a stretcher?" I asked him.

"No," he replied, "but this is where I learn."

Out he went, a word to the men outside, and I heard the roar of the truck. He was soon back, having had to make a short trip for nails. There was the sound of chopping and soon in came the men with two poles on which they had nailed a double grey blanket. In the meantime the neighbours had filled the bottom of the truck with hay and blankets.

It was a good stretcher, and finally we did get it and Steve through the door and into the truck. Someone mounted guard and we were off on our long journey to the hospital. Suddenly it occurred to me to inquire how, on such short notice, two such beautiful poles had been produced for the stretcher. I learned to my dismay that they were the top rails from the little fence that enclosed Steve's front yard. Still, Steve didn't begrudge his poles, and he always wears a broad smile when we meet.

I shall never forget that drive! A dense fog such as is seldom seen inland, settled down upon us. We lowered our lights and strained our eyes in an effort to keep on the road, but on we must go at all events.

When we arrived in Canora the town was in darkness, but in one café a light still burned. From this café we telephoned the doctor, and promised to return for coffee. We drove the remaining mile to the hospital, and be it said to the credit of the staff, they accepted our late arrival cheerfully and gave Steve immediate care. He had arrived tired, but in good condition.

How good our coffee tasted. Warmed and much less sleepy we set out for Sturgis where we arrived in the cold, grey dawn. We had travelled one hundred and nine miles.

So you see what travel time can mean on a rural nurse's time-sheet, and why we look with dismay at a daily time-sheet which reads "Cases two."

Nor is life all one grand long adventure in wooded solitudes. Our little villages are thriving and modern. We step up to a well-equipped office to interview the doctor, or down to the town hall to conduct a baby clinic. Sometimes we drive five miles or so on a good highway to examine some forty pupils in an up-to-date rural school.

The board is made up of staunch friends who understand local conditions and who are always ready to help and encourage one.

There is much variety in work of this type. Perhaps the hardest thing to face is the winter, when, owing to deep snow, parts of the district are inaccessible. Then a certain amount of monotony is bound to creep in.

But rural life is life, just as in the city. Try it, and you will see!

(V.O.N. News Letter, November, 1930.)

Institute of Public Health
Faculty of Public Health of the
University of Western Ontario
LONDON CANADA

News Notes

ALBERTA

Edmonton: The annual business meeting of the Edmonton Association of Graduate Nurses was held in the Y.W.C.A. parlors, January 21st, 1931. Miss J. Chinneck, convener of the Nominating Committee, submitted to the meeting the slate of officers for the ensuing year. Mrs. K. Manson was re-elected President for the third term. Miss Ward was elected Treasurer, and Miss C. Davidson was re-elected Secretary for the third term. A vote of thanks for her services in the capacity of Treasurer for the past five years was tendered Miss S. C. Christensen, retiring Treasurer. Miss Sproule, Registrar, gave an interesting report. Miss Sproule showed the demand for private duty nurses to be just half that of the previous year. Hourly nursing was suggested as a solution, and it was left to the private duty committee to bring in a report after discussion.

Miss Mary McCuaig, Local Superintendent of the V.O.N. in Edmonton, has been appointed Western Supervisor. This covers the country west of the Great Lakes. Many social functions have been given in Miss McCuaig's honour, showing the esteem in which she was held by her many friends in Edmonton. The Association and fellow-workers extend to Miss McCuaig their heartiest wishes for every success in her new office.

Miss V. R. Shipman succeeded Miss Mary McCuaig as Superintendent of V.O.N. nurses in Edmonton. Miss Shipman is a graduate of the Toronto General Hospital, and holds a diploma in Public Health Nursing from the University of Toronto. She has had a broad experience in institutional and public health work. Edmonton nurses wish Miss Shipman much success and happiness in her work in that City.

Miss K. S. Brighty, Superintendent of Public Health Nurses, gave a talk to the United Farm Women of Alberta at their convention in Calgary, January 24th. Her subject was "Maternal and Infant Welfare". Miss A. L. Conroy, Lecturer for the Provincial Public Health Department, was in charge of the Alberta Health Exhibit which was shown at the U.F.W.A. Convention. The many friends of Miss E. S. Fenwick, Superintendent of Nurses, University Hospital, will be sorry to hear of her recent illness, from which, happily, she is making a good recovery. Miss Elizabeth Kenwell, Miss A. E. Lord, and Miss Marion C. Story have accepted positions on the permanent staff of the Public School Nursing Branch. Miss Marion Graham has returned from Montreal where she was taking special work in the Royal Victoria Hospital, and is on the nursing staff of the Royal Alexandra Hospital.

BRITISH COLUMBIA

Vancouver: The annual meeting of the Vancouver Graduate Nurses Association took place on January 14th, in the club rooms of the Canadian National Institute for the Blind, with Miss M. Duffield, President, in the chair. Following the disposal of the general business of the meeting, the election of officers took place. One of the most outstanding pieces of work done by the Association during the past year was the establishment of a relief fund for the unemployed members of the profession. So far, the scheme seems to be working very satisfactorily. Membership in the Association is steadily increasing. In the annual report of the President for 1930, Miss M. Duffield says in part: "We can say, I think, that a great many events of importance have happened in the nursing world of Vancouver and Canada since last January. In the first place, the Private Duty Section brought into operation, in Vancouver, after a great deal of work and delay, the 10-hour duty, which has proved very successful, and, as far as we are able to discover, no one has suffered from the change of hours. The nurses themselves have benefited by having more time for themselves."

Six delegates were sent to the general meeting of the Canadian Nurses Association, held in Regina in June, 1930. At this meeting Dr. Weir, Director of the Survey on Nursing Education in Canada, compared the status of nurses in regard to education to that of the members of other professions in a not altogether complimentary way. Dr. Weir, during 1930, issued questionnaires to the nurses, but unfortunately there was much delay in answering. Dr. Weir showed great patience, although insistent that they all be answered. To assist in this, the Vancouver Graduate Nurses Association decided to appoint a committee to deliver the questionnaires to nurses who had not yet answered them, the same committee collecting the finished article the next day. This resulted in 431 completed questionnaires being received.

The Medical Association was asked to co-operate with the Registrar as far as possible in calling the nurses who had been longest on the list, and they have most cordially agreed to do this, and to help out the employment situation in every way possible.

Much appreciation is felt for the work done by the Ways and Means Committee during the year, for it was through their efforts in raising funds that the Association was able to give work to several nurses and also help patients who would not have been able to afford a special. In this way help was provided two people at the same time, and things on the whole were made a little easier.

General Hospital, Vancouver: On January 20th, 1931, the Alumnae held a special meeting in the Rotunda of the Home. Dr. Haywood, newly-appointed General Superintendent of the Hospital, was present and gave a most interesting and helpful address on the question of our Sick Nurses Benefit Fund, outlining a plan for group insurance for Alumnae members which has been tried and found satisfactory in Montreal. The meeting was well attended, and after lengthy discussion it was decided to appoint a committee to go more fully into the question.

On February 3rd, at the regular meeting, this committee reported that a letter was being sent to all Vancouver General Hospital graduates to try to interest as many as possible in this splendid idea, and to find out how many might be interested in it.

MANITOBA

Brandon: The regular meeting of the Brandon Graduate Nurses Association was held on February 3rd, at the home of Mrs. Dr. Pierce. A most interesting report, written by Miss Meadows, delegate from the Private Duty Section to the annual meeting of the Manitoba Association of Registered Nurses, which was held in Winnipeg, was read by Miss McLeod. The business meeting was followed by an enjoyable social hour.

St. Boniface Hospital: Miss Ellen M. Farrell, former Secretary of the Alumnae Association, has accepted a position on the staff of the Surgical Department of the Mental Hospital at Selkirk, Man.

Misericordia Hospital, Winnipeg: At the monthly Alumnae meeting in January, Dr. J. D. McEachern gave an interesting illustrated lecture on "Closed Drainage for Empyemia Cases". On the evening of February 2nd the 1931 graduating class entertained the Alumnae members at the Nurses Home. Following a visit to the different rooms of the home, luncheon was served in the Reception Room. The sympathy of the Alumnae is extended to Miss Gertrude Boulton on the death of her father.

Winnipeg: Mrs. J. F. Morrison will head the Manitoba Association of Registered Nurses as a result of the elections held at the annual meeting in the Parliament Buildings recently. Increased activities during 1930, resulting in the appointment of a paid secretary, were reported. The dinner meeting, held at the Mikado tea-rooms, featured an address by Father Morton, of St. Mary's Cathedral, who spoke on "Self-Determination." Practice of self-control and independent thinking led to the creation of an invaluable habit, Father Morton said, which would contribute to one's happiness and success. Despite the limitations of heredity, there were emotions and passions which the individual could control through self-will. Fifteen families which had been visited by tuberculosis were given Christmas hampers, the welfare committee reported. In addition to giving relief where necessary, to members, the Association has given training to four native nurses in India, and paid the salary of a trained nurse at Patna Hospital. The 1931 Executive Committee was elected as follows: Miss J. Purvis, First Vice-President; Miss C. Kettles, Second Vice-President; Miss J. McNally, Third Vice-President. The Board will consist of: Misses A. E. Russell, K. W. Ellis, R. Dickie, A. Beggs, E. Ironside, E. Parker, A. Besant, P. Brownell, A. D. McLeod. Rev. Sister Meade, Rev. Sister Vincent. Miss M. Reid is convener, Nursing Education; Mrs. E. M. Doyle, Private Duty; Miss I. McDiarmid, Public Health; Miss. G. Hall, Press and Publications; Misses E. Carruthers, A. LaPorte, Naser and Mallory, Directory; Miss C. Taylor, Social and Programme; Miss W. Carruthers, Sick Visiting; Miss M. Meehan, Membership; Mrs. J. F. Morrison, Red Cross Enrolment. Miss F. Robertson was appointed as representative to the Central Council of Social Agencies; Miss Allan, Victorian Order of Nurses; Miss Willard Hill, Local Council of Women; Miss A. Bell, Junior Red Cross; Miss M. Wannocott, New Canadians.

NEW BRUNSWICK

Victoria Public Hospital, Fredericton: At a recent meeting of the Graduate Nurses Association it was decided to have a bridge once a month, charging a small fee, in order to raise funds for the Association. So far, each bridge has been well attended and the social evenings are greatly enjoyed.

St. Stephen: The members of the local chapter of the N.B. Association of Registered Nurses held their annual meeting in January. Reports showed an increase in membership and in funds. The following officers were elected: President, Miss M. McMullen; Vice-President, Miss C. M. Boyd; Secretary-Treasurer, Miss M. Dunbar; Publications, Miss M. McMullen and Miss Helen Boone; Entertainment, Miss Sherrard, Miss O'Brien, Miss Bavis and Miss Cochrane.

Members of the Association sold tickets for "The Cohens and Kellys in Africa," which was being shown at the Queen Theatre, February 4th and 5th, and candy was sold in the lobby of the theatre. $81.00 was realised from the sale of tickets and candy—lots of fun and not very hard work!

Chipman Memorial Hospital, St. Stephen: Miss Helen Boone is a surgical patient in the hospital. Miss S. Murphy and Miss M. Kirkpatrick are engaged in private duty work in St. John, N.B.

Fisher Memorial Hospital, Woodstock: Miss Christina Hellman, night supervisor at the Fisher Memorial Hospital, is convalescing at her home in Meductic from a throat operation performed by Dr. London, of Montreal. Her many friends will be glad to know that she is much improved in health.

General Public Hospital, Saint John: The regular monthly meeting of the Alumnae was held in the Nurses Home on February

2nd. Mrs. J. Vaughan, President, was in the chair. After the routine business, the reports for the bridge held in January were submitted. After all expenses were paid, there was a balance of $165.00. This is to be used as a nucleus for the amount required to furnish a ward in the new hospital, which responsibility has been undertaken by the Alumnae.

ONTARIO

Paid-up subscriptions to "The Canadian Nurse" for Ontario in February, 1931, were 1,187, five less than in January, 1931.

APPOINTMENTS

Miss Gertrude Spanner (Hospital for Sick Children, Toronto, 1914), has been appointed Dean of the School of Nursing of the Good Samaritan Hospital, Los Angeles, Calif. Miss Marjorie Frances (Hospital for Sick Children, Toronto, 1930) is taking post-graduate work at Boston Children's Hospital. Miss Helen Anderson (Hospital for Sick Children, Toronto, 1930) to the staff of the Thistletown Branch of the Hospital for Sick Children. Miss Helen McCallum (Hospital for Sick Children, Toronto, 1930), in charge of the infants' ward of the Children's Memorial Hospital, Montreal. Misses Gertrude Evans (Hospital for Sick Children, 1917) and Dorothy Priestly (Hospital for Sick Children, 1926), to the staff of the Vancouver General Hospital. Miss Lilian Hinton (Oshawa General Hospital, 1928) has returned to the Oshawa General Hospital as Technician.

DISTRICT 1

The sixth annual meeting of the Registered Nurses Association of Ontario, District 1, was held in the Colonel Gartshore Nurses Residence of Victoria Hospital, London, on January 24th. Two hundred nurses were in attendance.

The invocation was given by the Rev. Dr. Ross, of St. Andrews United Church, followed by addresses of welcome from Msgr. Stanley, Rector of St. Peter's Cathedral, and Mayor Hayman, of London.

Splendid reports of the year's activities were given by the Secretary-Treasurer and by Conveners of Sections.

The election of officers for the ensuing year was as follows: President, Miss Nellie Gerard, Windsor; Vice-President, Miss P. Campbell, Chatham; Secretary-Treasurer, Mrs. Mary Walker, Sarnia; Councillors, Miss Anne Evans, London, Miss Anna Boyle, London, Miss Hazel Hastings, St. Thomas, Miss F. C. Ritchie, Petrolea, Miss Mabel Hay, Windsor, and Mrs. Jean Wilson, Strathroy; Convener, Nursing Education Section, Miss Mary Jacob, London; Public Health Section, Miss Mabel Hardie, London; Private Duty Section, Misses H. Hastings and E. Reaman, St. Thomas.

Luncheon was served at the close of the morning session, the Alumnae Associations of St. Joseph's Hospital, Ontario Hospital, Victoria Hospital and the Edith Cavell Association acting as hostesses.

The afternoon session was opened by Dr. J. C. Fallis, Superintendent of Victoria Hospital, who extended a cordial welcome. He introduced the Hon. W. G. Martin, Minister of Public Welfare, who gave an interesting talk on his work. Miss Ruth Lewis, M.A., Psychologist of Ontario Mental Health Clinics for Western Ontario, chose as her subject, "Some Aspects of a Mental Health Clinic". Miss C. Gillies of the Eye, Ear, Nose and Throat Department of Victoria Hospital, gave a very practical demonstration of cataract and mastoid dressings. The afternoon session closed with an address by Dr. Harold Little on the story of cod liver oil—Sunshine and Viosterol. The nurses attending the meeting were guests of the Ontario Hospital at a delightful tea following the afternoon session.

VICTORIA HOSPITAL, LONDON: Mrs. Edith Millard (1930) has been appointed assistant supervisor of the private pavilion. Miss Macie Benbow (1929) has been appointed supervisor of the military ward. A social service branch has recently been opened in connection with the Out-Patient Department. Miss Mildred Thomas (1920) has been placed in charge.

MEMORIAL HOSPITAL, ST. THOMAS: The Annual Dance of the Alumnae Association, held recently in the Masonic Temple, proved a most successful event. Attendance was close on four hundred. The programme included a number of novelty dances and amusing favours were presented to the guests. The long tables holding the buffet lunch were decorated in the hospital colors, purple and gold, while daffodils in white and gold, with matching tapers, added an effective touch. Miss I. Matheson looked after the invitations; Miss Hastings, the novelties; Miss Grant, the music, and Mrs. F. Penhale was in charge of the luncheon arrangements. Mrs. T. Keith was convener of the reception committee. Many guests from Toronto, London, Aylmer, Tillsonburg, Springfield, Lambeth, Dutton, Sheddon and surrounding districts were in attendance. The success of the dance, made possible by the energetic work of the Alumnae members, will mean a substantial addition to the Alumnae's fund for a new nurses' home.

DISTRICT 2

KITCHENER AND WATERLOO HOSPITAL: At a recent meeting of representatives of District 2, Miss Bingeman, Lady Superintendent, Freeport Sanatorium, was appointed convener of the committee in charge of the arrangements for the convention of the Registered Nurses Association of Ontario, to be held in Kitchener, Easter Week, April 9th to 11th, 1931.

On December 2nd, 1930, a reception was held in the Nurses Home to welcome Miss K. W. Scott, formerly Superintendent of the Sarnia General Hospital, now Superintendent of the Kitchener and Waterloo Hospital.

GENERAL HOSPITAL, WOODSTOCK: On November 8th, 1930, members of the Alumnae held a very successful tea in the Nurses Residence. Miss Lenora Armstrong (1920) who has been engaged in missionary work in Korea, is home on furlough. The graduate nurses and student nurses were entertained by

Institute of Public Health
Faculty of Public Health of the
University of

the doctors at an informal dance on November 25th, in the Eastern Star Rooms, the guests being received by Miss Helen Potts, Superintendent, and Miss Gladys Mill, Assistant Superintendent.

DISTRICT 4

Mack Training School, St. Catharines: The January meeting of the Mack Training School Alumnae was held at the Leonard Nurses Home, January 7th. After a lengthy business discussion, Mrs. Hagarth, of the Public Health Department, Toronto, presented two very interesting films on "The Gift of Life". Appreciation was extended to Mrs. Hagarth by Mrs. W. Durham and Mrs. Platts, after which the meeting adjourned. The February meeting was held at the home of Mrs. Chas. Hesburn, February 4th. After the routine business, the hostess entertained at a pleasant bridge of several tables, followed by dainty refreshments.

DISTRICT 5

Toronto: The January meeting of the Centralised Lecture Committee for Student Nurses (Instructors' Section) was held on January 8th, at the Nurses' Residence, Toronto General Hospital. Short papers on the following subjects were read, discussion following each: "Supplementary Teaching Aids," "Illustrative Equipment for Classroom Teaching," and "Bedside Instruction to Student Nurses".

Grant Macdonald Training School for Nurses, Toronto: The annual meeting of the Alumnae was held January 26th, when the election of officers for 1931 took place. While awaiting election returns, Mrs. Ash read a paper on "Mothercraft Service". At the close of the meeting refreshments were served.

General Hospital, Oshawa: The annual meeting of the Alumnae Association was held at the nurses residence on January 5th, with Miss A. Scott in the chair. Miss E. Hogarth gave a report of the activities of the past year, and the treasurer, Miss J. Cole, in her financial statement, showed that the Alumnae had a good balance on hand. Miss E. Hogarth gave a report on the District 5 meeting held in Toronto in November.

The annual "At Home" of the Association was held on January 30th, 1931, at the Masonic Temple, when a very pleasant evening was enjoyed.

The sympathy of the Association is extended to Mrs. (Dr.) B. A. Brown (Laura Huck, 1921), on the death of her father.

Western Hospital, Toronto: The regular monthly meeting of the Alumnae Association was held in the Edith Cavell Residence, January 13th, 1931. A large number of members were present. The speaker of the evening was Dr. Frank R. Scott, who gave a particularly interesting address on the subject of "Diseases of the Thyroid Gland".

St. Michael's Hospital, Toronto: Miss Elizabeth Regan, Instructor, while on a short holiday at London, Ont., recently, was taken ill, having to undergo a major operation in a London hospital. Her many friends will be pleased to learn that Miss Regan made favourable recovery, and was expecting to return to her duties in Toronto some time early in March.

The sympathy of the Alumnae is extended to Mrs. Thos. E. Scully (Ann Dolan, St. Michael's Hospital, Toronto), on the death of her husband.

Women's College Hospital, Toronto: The regular meeting of the Alumnae was held at the Clinic House, Grenville St., on December 8th. After the brief business session, Miss Anderson gave a detailed account of the progress of the new building. Miss Anderson has been President of the Board for many years. Dr. Marian Kerr gave a most interesting talk on her work at the "Rotunda" in Dublin. At the January meeting, Miss Roberts (1924) spoke on government work in connection with the Women's Institute of Ontario.

Miss McAughtrie (1930) leaves shortly for Johns Hopkins Hospital to take up postgraduate work. Miss Tillet, who sustained an injury while taking a course in Montreal, has been able to leave the hospital.

DISTRICT 8

Civic Hospital, Ottawa: The second annual meeting of the Alumnae Association was held in the nurses residence, Friday, January 16th. After the reading of the various reports which testified to a very successful year both socially and financially, the following officers and committees were elected for the ensuing year: Honorary President, Miss Gertrude Bennett; President, Miss Evelyn Pepper; First Vice-President, Miss Elizabeth Graydon; Second Vice-President, Miss Dorothy Moxley; Recording Secretary, Miss Greta Wilson; Corresponding Secretary, Miss Eileen Graham; Treasurer, Miss Winnifred Gemmill; Councillors, Mrs. G. W. Dunning, Misses Elizabeth Curry, Gertrude Moloney, Mary Lamb, Gladys Moorehead; Membership Committee, Convener, Miss Winnifred Gemmill, Miss E. Webb, Miss Dorothy Kelly, Miss Lera Barry, Miss Edna Osborne, Miss M. Downey, Miss G. Froats; Flower and Sick Visiting Committee, Convener, Miss Margaret McCallum, Miss Nichol, Miss Beryl Edey, Miss Martha MacIntosh, Miss Emily Fallas, Miss Elsie Nesbitt, Miss Alma Lindsey; Representatives to Central Registry, Miss Myrtle Tanner, Miss Inda Kemp; Correspondent to "Canadian Nurse" and Press Representative, Miss Edna Osborne.

QUEBEC

The Montreal General Hospital: Mrs. Kierstead has taken a position in the Newport Hospital, Newport, Vermont. The engagement is announced of Miss Lillian Brissenden (1917), to Charles K. Morrison, of Victoria, B.C. The wedding to take place in Vancouver. Miss Messenger (1930), is taking a post graduate course in the operating room. Miss Pauline Brown (1927), has resigned her position as assistant in the operating room, and has been succeeded by Miss Parker (1930). The sympathy of the

Association is extended to Miss G. Doherty on the death of her mother.

Sherbrooke Hospital: The annual meeting of the Alumnae was held January 28th, at the MacKinnon Memorial, when 28 nurses sat down to a turkey dinner. Immediately after dinner, several business items were discussed and the election of officers took place. Miss Jean Fenton has resigned her position as Assistant Superintendent, and accepted a position in the Orleans County Hospital, Newport, Vermont, as Superintendent. In her honour a very enjoyable sleigh drive and party was given by the staff and student nurses. Miss Fenton was presented with a handsome mahogany tray with silver handles, from the staff, and a china tea service from the student nurses; also a beautiful, fitted leather suitcase from the staff of doctors. Mrs. Nelson Lothop entertained in honour of Miss A. I. McAuley, at a miscellaneous shower; Mrs. G. Bryant, at a kitchen shower, and Mrs. J. H. Bryant, at a "What to do" party, which proved very jolly and enjoyable. Miss Verna Beane will succeed Miss Fenton as Assistant Superintendent, and Miss Alfreda Dearden will take Miss Beane's place as supervisor of the operating room. Miss Douglas, a recent graduate of the hospital, will be night supervisor. The sympathy of the Association is extended to Miss Norah Arguin on the death of her father.

Jeffery Hale's Hospital: The following members of the Alumnae attended the annual meeting of the Registered Nurses Association of the Province of Quebec: Misses C. E. Armour, H. A. MacKay, M. E. Savard, and Mrs. S. B. Baptiste.

Woman's General Hospital, Westmount: The annual meeting of the Alumnae was held on January 19th, 1931, for the transaction of business and the election of officers. The Association is much indebted to the members of the medical staff who have given addresses at the monthly meetings. Dr. B. A. Conroy was the speaker in November and Dr. George Stream in December. Both addresses were much appreciated.

Western Hospital, Montreal: At the annual meeting, held on January 12th, Miss Bertha Birch was elected president, and a vote of thanks was extended to Miss Nash, retiring president, after three years service. Miss Macwhirter is in Woodstock owing to the illness of her mother. Miss Ruth Levitt spent Christmas and the New Year with her mother in Montreal. Miss M. Morrison is spending the winter months at her home due to the illness of her sister. The sympathy of the Alumnae is extended to Miss Freda James, on the death of her father, which occurred in Boston on January 27th, 1931.

SASKATCHEWAN

Regina: On January 8th, the regular monthly meeting of the Registered Nurses Association of Saskatchewan, Regina Branch, was held at the Nurses Residence of the Regina General Hospital, with forty-two members present. Miss Ruby Simpson, of the Public Health Staff, Regina, gave a very interesting address on her six-weeks post graduate course taken at several hospitals in London, England. Miss A. M. Hutt rendered two solos.

On January 17th, about 350 guests were entertained at a tea given by the Regina Branch of the Registered Nurses Association of Saskatchewan, in the Nurses Residence of the Regina General Hospital. Receiving were: Miss Margaret McRae, President of the Association, Miss Vera Pearson, Mrs. S. R. D. Hewitt, and Mrs. W. M. Van Valkenburg. Miss Ruby Simpson and Miss Jean McKenzie had charge of the tea room. Mrs. J. T. Waddell was convener of the Refreshment Committee. Tables were charmingly arranged with gleaming silver and china, with centre baskets of roses, iris and other flowers, interspersed with maiden hair fern. $110.00 was realised from the tea.

General Hospital, Regina: In conjunction with the Regina General Hospital, a Psychopathic Ward has been opened, containing twenty-two beds. Miss Margaret McDonald, graduate of the Winnipeg General Hospital, has taken charge of this department during the day, and Miss S. Hastings, also a graduate of the Winnipeg General, during the night. Miss Freda Trueman, of Regina, and Miss Lillian Winn, of Wolseley (both 1929), have been patients at Fort San, Sask., for several months, and at Christmas time were able to return to their homes. Miss H. J. Smith (Winnipeg General Hospital, 1930), is taking a three-months post graduate course in operating room technique and management in the Regina General Hospital.

On January 13th, the Alumnae met at the Nurses Residence for the purpose of election of officers for 1931: Miss Dorothy R. Wilson being chosen as Honorary President; Miss Myrtle Lythe, President; Miss Helen Wills, First Vice-President; Miss Lily Smith, Second Vice-President; Miss B. Calder, Secretary; Assistant Secretary, Miss A. Forrest; Treasurer, Miss A. Clarke; Press, Miss M. E. Buker; Convener, Programme Committee, Miss O. Morton; Refreshments, Miss D. Kerr and Miss H. Wills; Sick Nurses, Miss Grace Thompson.

Miss Mabel E. Buker, who has for some time been a patient at Fort San, Sask., has returned to Regina where she has taken a position in the Records Department of the Regina General Hospital.

City Hospital, Saskatoon: The nursing staff of the hospital held a delightful reception on January 28th in their newly completed new home, when they were "At home" to the Alumnae. The new building is a most worthy addition to the hospital unit, and the guests were escorted by uniformed student nurses through the beautiful rooms and offices. Miss G. M. Watson, Superintendent of Nurses, was assisted by Mrs. W. H. Clare in welcoming the guests.

Mrs. H. Elliott (G. Lacheur), President of the Alumnae Association is convalescing after a recent illness.

BIRTHS, MARRIAGES AND DEATHS

BIRTHS

ANDERSON—On December 29th, 1930, at Simcoe, Ont., to Mr. and Mrs. Beverley Anderson (Marion K. Smith, Hamilton General Hospital, 1927) a son.

BAKER—In January, 1931, at Toronto, to Dr. and Mrs. Stanley Baker (Dorothy Barker, Hospital for Sick Children, Toronto, 1926), a son.

BLAKELEY—On November 30th, 1930, at Toronto, to Mr. and Mrs. F. Blakeley (Grace Hards, The Wellesley Hospital, Toronto, 1929), a daughter.

BUCHANAN—On January 16th, 1931, at St. Catharines, Ont., to Mr. and Mrs. Neil Buchanan (Caroline Freel, St. Catharines General Hospital), a son.

CARROLL—On November 21st, 1930, at Toronto, to Mr. and Mrs. Wm. Carroll (Anna Carr, The Wellesley Hospital, Toronto, 1927), a son.

COULTER—On January 21st, 1931, at Vancouver, to Mr. and Mrs. John Coulter (Margaret Turner, Edmonton General Hospital), a daughter.

FARMER—On January 24th, 1931, to Mr. and Mrs. E. Farmer (Margaret Campbell, Ottawa Civic Hospital, 1926), a son.

FOX—On November 27th, 1930, at Toronto, to Mr. and Mrs. A. M. Fox (Fern Johnston, The Wellesley Hospital, Toronto, 1923), a son.

HARVEY—On November 23rd, 1930, at Sparta, Ont., to Mr. and Mrs. W. Harvey (Mildred L. Gregg, Memorial Hospital, St. Thomas, Ont., 1928), a son.

HILLMAN—On December 15th, 1930, to Mr. and Mrs. Fred Hillman (Rachel Lawrence, Fisher Memorial Hospital, Woodstock, N.B., 1926), a daughter.

GRANGER—On February 8th, 1931, at Vancouver, to Mr. and Mrs. John Granger (Freda Marlin, Vancouver General Hospital), a daughter.

LEACH—On December 29th, 1930, at Edmonton, Alta., to Mr. and Mrs. E. Leach (Ruth Mae Hale, Royal Alexandra Hospital, Edmonton, 1924), a daughter.

McLELLAND—On January 7th, 1931, at Toronto, to Dr. and Mrs. Harold McLelland (Maisie Leitch, Hospital for Sick Children, Toronto, 1919), a daughter.

MAIN—In December, 1930, at Montclair, N.J., to Mr. and Mrs. Orrin Main (Constance Proctor, Hospital for Sick Children, Toronto, 1926), a son.

MILES—Recently, at Windsor, Ont., to Mr. and Mrs. Alfred Miles (Mary Drinwell, Oshawa General Hospital, 1927), a son (still-born).

MILLS—In December, 1930, at Lachine, P.Q., to Mr. and Mrs. John Mills (Gladys Heartley, Jeffery Hales Hospital, Quebec, 1917), a daughter.

MULLINS—On December 16th, 1930, to Mr. and Mrs. Mullins (Louise Wood, Hamilton General Hospital, 1927), a daughter.

PEGRUM—Recently, at Los Angeles, Calif. to Mr. and Mrs. D. Pegrum (Marion Phensey, Royal Alexandra Hospital, Edmonton, Alta., 1921), a son.

ROBERT—On February 4th, 1931, at Windsor, Ont., to Dr. and Mrs. J. Terrence Robert (Norah Gleeson, St. Michael's Hospital, Toronto, 1925), a daughter.

SHREVES—On January 25th, 1931, at Halifax, N.S., to Mr. and Mrs. Shreves (Edith Glass, Jeffery Hales Hospital, Quebec, 1918), a daughter.

SPARKES—On December 20th, 1930, at Kamsack, Sask., to Mr. and Mrs. Ralph E. Sparkes (Elsie Reid, Toronto General Hospital, 1925), a daughter.

THOMAS—On January 16th, 1931, at St. Stephen, N.B., to Mr. and Mrs. Allison Thomas (Mary Stairs, Chipman Memorial Hospital, St. Stephen), a daughter.

WATSON—On January 18th, 1931, at Toronto, to Mr. and Mrs. Jas. Watson (Florence Smith, The Wellesley Hospital, Toronto, 1925), a daughter.

WHITE—On January 1st, 1931, at Edmonton, Alta., to Mr. and Mrs. A. H. White (Hazel Stuckey, Royal Alexandra Hospital, Edmonton, 1921), a son.

WHITSIDE—On January 18th, 1931, at Toronto, to Mr. and Mrs. Whitside (Rita Hodgson, The Wellesley Hospital, Toronto, 1924), a daughter.

WILLIAMS—On November 30th, 1930, at St. Thomas, Ont., to Mr. and Mrs. Verne L. Williams (Olga Oke, Memorial Hospital, St. Thomas, 1925), a son.

YOUNG—In January, 1931, at Quebec, to Mr. and Mrs. Chas. Young (Irene Fellows, Jeffery Hales Hospital, Quebec, 1918), a daughter.

MARRIAGES

BERHNARDT—SLIMMON — On August 20th, 1930, Stella Slimmon (Kitchener and Waterloo Hospital) to Herman Bernhardt.

BIRD—WILLISTON—On December 24th, 1930, at New York, Edith Williston (Victoria Public Hospital, Fredericton, N.B.), to John Bird, of Edmunston.

BLAKE—BAXTER—On January 19th, 1931, at Toronto, Faith Baxter (Hospital for Sick Children, Toronto, 1927), to William Edward Blake, of Hamilton, Ont.

BRADLEY—SCARLETT — On November 8th, 1930, at Detroit, Mich., Elizabeth Scarlett (Montreal General Hospital, 1916) to Frank Bradley.

BRYANT—McAULEY—On January 28th, 1931, Ann Isobelle McAuley (Sherbrooke Hospital, Sherbrooke, Que.) to J. H. Bryant, of Sherbrooke.

CONNORS—MATHESON — Recently, at St. George, Mattie Matheson (Victoria Public Hospital, Fredericton, N.B., 1923) to Stanley Connors, of Toledo, Ohio.

FORREST—SHARPE — Recently, Emma Sharpe (Chipman Memorial Hospital, St. Stephen, N.B.), to Harry George Forrest, of Concord, N.H.

GERNHELDER—SANDERSON — On September 3rd, 1930, Verna Sanderson (Kitchener and Waterloo Hospital) to George Gernhelder.

GIBSON—BERRIDGE—On January 15th, 1931, at Winnipeg, Ethel K. Berridge, to James Gibson.

GILLESBY—RUSK—On December 25th, 1930, Grace Rusk (Owen Sound General and Marine Hospital, 1923) to James Gillesby, of Owen Sound, Ont.

HODKINSON—SAUNDERS — In December, 1930, at London, Ont., Jean Saunders (Memorial Hospital, St. Thomas, Ont., 1930), to William Hodkinson.

LEE—GRAHAM—On January 19th, at Vancouver, Dorothy F. Graham, 1931 (Vancouver General Hospital) to William C. Lee.

LINDAMOOD—MILLER — Recently, at Guelph, Ont., Mae Miller (Victoria Hospital, London, Ont., 1926) to Western Wilbert Lindamood, of New York.

McLEOD—McKECHNIE — On December 29th, 1930, at Toronto, Flora McKechnie (Vancouver General Hospital) to Earl McLeod.

MELLISH—HARTLEY — On September 24th, 1930, at Toronto, Ont., Viola C. Hartley (Women's College Hospital, Toronto, 1930) to Rev. Gordon Day Mellish, of Miners Bay, Ont.

MITCHELL—SADDINGTON—On December 20th, 1930, at Port Credit, Ont., Frances Saddington (The Wellesley Hospital, Toronto, 1927) to Jas. Mitchell.

MUSHRALL—HUNTER — Recently, at Grand Falls, Christina Hunter (Victoria Public Hospital, Fredericton, N.B., 1928) to Mr. Mushrall.

NORMAN—HANSEN—On November 1st, 1930, Hilda Hansen (Grant MacDonald Training School, Toronto, 1926), to Wm. Norman, of Bayonne, N.J.

RANKIN—MURPHY—On January 29th, 1931, Anne L. Murphy (Jeffery Hales Hospital, Quebec, 1920), to Robert Rankin, of Montreal.

RICE—GENDRON—On December 31st, 1930, Eileen Gendron, Sherbrooke, Que., to Charles M. Rice, of Montreal.

SCOTT—KNOX—Recently, in Vancouver, Elizabeth Knox (Vancouver General Hospital, 1927), to David Reid Scott.

STALKER — AITCHESON — On January 9th, 1931, at Toronto, Olive Atcheson (The Wellesley Hospital, Toronto, 1922), to Ross Stalker.

TANTON—SCOTT—On December 26th, 1930, at Toronto, Myrtle Rose Scott (Women's College Hospital, Toronto, 1924), to Cyril Tanton, of Sundridge, Ont.

WASSON—JONES—On January 17th, 1931, at West Vancouver, Florence G. Jones (Vancouver General Hospital), to Everett L. Wasson.

DEATHS

ANDERSON—On January 10th, at Simcoe, Ont., Mrs. Beverley Anderson (Marion K. Smith, Hamilton General Hospital, 1927).

BOLTON—In December, 1930, at St. Thomas, Ont., Jessie Bolton (Amasa Wood Hospital, 1919), following an operation.

STUBBERFIELD—On February 6th, 1931, at Petersburg, Fla., Edith Stubberfield (St. Michael's Hospital, Toronto).

SUTHERLAND—On January 17th, 1931, Mrs. Sutherland (Dorothy Lewis, City Hospital, Saskatoon, Sask., 1925), following an operation.

ASSOCIATION OF REGISTERED NURSES FOR PROVINCE OF QUEBEC

Examinations for Qualifications as Registered Nurse in the Province of Quebec, will be held in Montreal and elsewhere, on May 4th, 5th, 6th, 1931.

Those wishing to write, must apply for forms, etc., to the Registrar, and all applications must be in the office of the Association before April 1st. No application can be considered after that date.

E. FRANCES UPTON, R.N.,
Executive Secretary and Registrar,
Room 221, 1396 St. Catherine Street West,
MONTREAL, P.Q.

EXAMINATIONS FOR REGISTRATION OF NURSES IN NOVA SCOTIA

are to take place Wednesday and Thursday, 20th and 21st of May, 1931. Candidates are requested to send for their application forms at once and to return them, accompanied by initial registration fee of $10.00, and, if already graduated, their diploma, before 21st April, 1931.

No undergraduates may write unless they have passed successfully all their final Training School examinations and are within six weeks of completion of their time.

Official Directory

INTERNATIONAL COUNCIL OF NURSES

Secretary.. Miss Christiane Reimann, Headquarters: 14 Quai des Eaux-Vives, Geneva, Switzerland.

EXECUTIVE COMMITTEE, CANADIAN NURSES ASSOCIATION

Officers

Honorary President..............Miss M. A. Snively, 50 Maitland Street, Toronto, Ont.
President..................Miss F. H. M. Emory, University of Toronto, Toronto, Ont.
First Vice-President............Miss K. W. Ellis, Winnipeg General Hospital, Winnipeg.
Second Vice-President......Miss G. M. Bennett, Ottawa Civic Hospital, Ottawa, Ont.
Honorary Secretary..............Miss Nora Moore, City Hall, Room 309, Toronto, Ont.
Honorary Treasurer..............Miss R. M. Simpson, Parliament Bldgs., Regina, Sask.

COUNCILLORS

Alberta: 1 Miss Eleanor McPhedran, Central Alberta Sanatorium, Calgary; 2 Miss Edna Auger, General Hospital, Medicine Hat; 3 Miss B. A. Emerson, 604 Civic Block, Edmonton.

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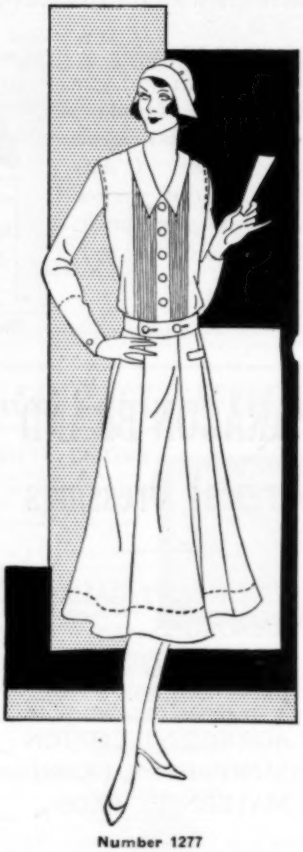

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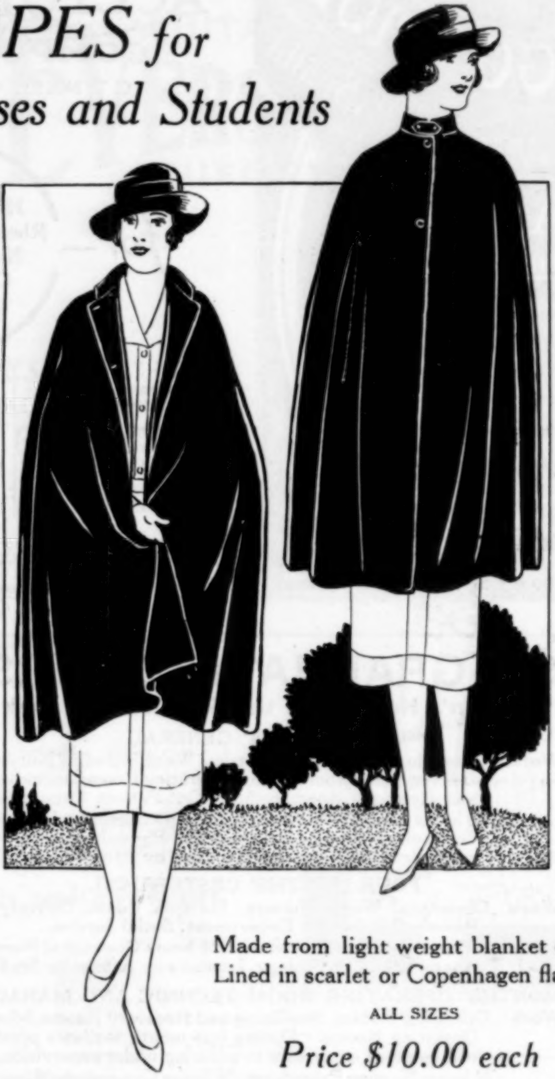

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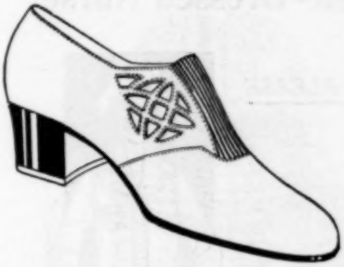

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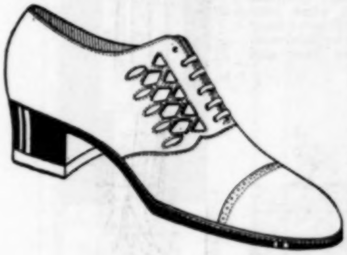

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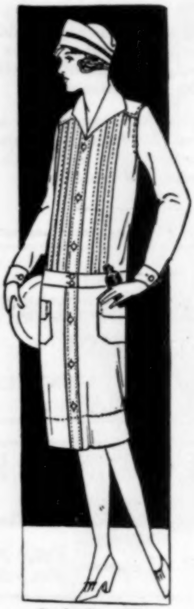

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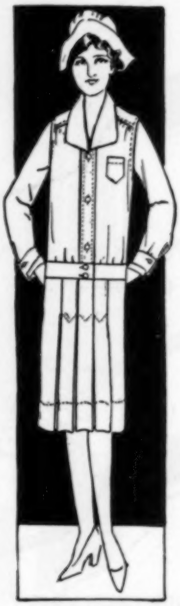

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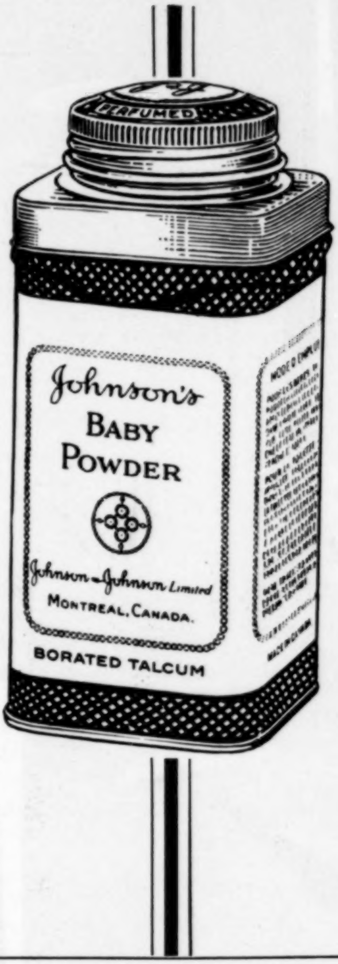

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